

Summary Plan Description

City of Scottsdale

Open Access High Level

CPOS II Plan through Aetna

Effective July 1, 2011

Welcome!

*This booklet is your guide to the benefits provided by the City of Scottsdale **Open Access High Level CPOSII Plan** through Aetna. In this booklet you will find detailed information concerning medical and prescription drug benefits provided under the Plan, how to access those benefits and important information concerning eligibility for you and your dependents. Please take the time to familiarize yourself with the contents of this booklet and refer to it when you need information about how the Plan works.*

If you cannot find the answer to your question(s) in this booklet, call Aetna Member Services at the toll-free number on your ID card. A trained representative will be happy to help you. For more information, go to the “Member Services” section found later in this booklet.

The City is actively working to promote a healthy lifestyle through the Live Life Well employee wellness program. Many chronic illnesses are directly related to the lifestyles we lead. As you read through this booklet, please take a few minutes to learn more about the wellness and disease management programs available through this Plan.

- *Routine physical exams and well baby care are covered at 100% under the plan when performed and coded as preventive by a participating provider.*
- *The Aetna 24-Hour Informed Nurse Line is available 24-hours a day 365 days per year to answer your health questions.*
- *You can get discount membership rates at various health clubs around the valley through Global Fit.*
- *Various women’s and men’s health programs including: Beginning Right Maternity Management Program, Women’s and Men’s Health Online Information and the Breast Health Education Center, Men’s Health Resource Center, Intellihealth, where you can find online information on a variety of topics.*
- *Aetna VisionSM Discounts - helps members save on eyeglasses, sunglasses, contact lenses and solutions, LASIK, and more. Best of all, it’s automatically included with the City of Scottsdale Open Access High Level CPOSII Plan at no extra charge.*

Important Note to Retirees: This plan provides benefits on a secondary basis compared to Medicare. All retiree plan members and dependents who are eligible for Medicare should enroll for Medicare so that the member does not assume Medicare claim costs. If a plan member who is eligible for Medicare does not enroll in Medicare, the plan will only pay secondary benefits. See the Coordination of Benefits section for further details.

The City of Scottsdale Open Access High Level CPOSII Plan is self-funded by the City of Scottsdale and administered by an independent organization, Aetna Life Insurance Company. Behavioral Health and Substance Abuse benefits are provided by CIGNA Behavioral Health on an insured basis. The Plan is not subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

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How the Plan Works

Plan participants have access to a network of participating Primary Care Physicians (PCP's), specialists and hospitals that meet Aetna's requirements for quality and service. These providers are independent physicians and facilities that are monitored for quality of care, patient satisfaction, cost-effectiveness of treatment, office standards and ongoing training. Your level of benefits will depend upon whether you use a provider from Aetna's Open Access CPOSII network when you seek medical care. Not every medical service, test or supply is covered by the plan, even if prescribed, recommended, or approved by your physician. It is your responsibility to know the copayments and what services are covered and what services are not covered.

When you use a provider that participates in the Aetna network, you receive benefits at the in-network level. You can go to any doctor in the network. The Plan will pay most eligible expenses at the coinsurance percentage stated in the Summary of Benefits after you meet an annual deductible. Once you meet the in-network out-of-pocket maximum, the Plan will pay your in-network expenses at 100%. If you receive care at the in-network level, you generally do not need to submit claim forms. The participating provider, hospital or lab will submit your claims. It is recommended that you check with Aetna Member Services to confirm that the provider listed in the Aetna directory is still a participating provider.

When you choose to use a health care provider that does not participate in Aetna's network, you will receive benefits at the out-of-network level. The Plan will pay most eligible expenses at a percentage of reasonable and customary charges after you meet an annual out-of-network deductible. Once you meet the out-of-network out-of-pocket maximum, the Plan will pay your out-of-network expenses at 100% of reasonable and customary charges. You must submit claim forms and arrange for utilization review and required pre-authorizations.

Important Plan Provisions

The Primary Care Physician

As a participant in the Plan, you will become a partner with your participating PCP in preventive medicine. Consult your PCP whenever you have questions about your health.

Each participant in the Plan is encouraged to select a Primary Care Physician (PCP) when enrolling, although this is not required. Your PCP serves as your guide to care in today's complex medical system and will help you access appropriate care and coordinate your care when using multiple providers.

Primary and Preventive Care

Your PCP or other primary care physicians that participate in Aetna's network (defined as Family and General Practice physicians, Internal Medicine physicians, Ob-Gyn physicians and Pediatricians) can provide preventive care and treat you for illnesses and injuries. The Plan includes coverage for routine physical exams, well-baby care, immunizations and allergy shots provided by a participating primary care physician. You are subject to the primary care physician copay when accessing care from a primary care physician. When receiving preventive care that is coded as preventive by the doctor, the copay is waived.

Specialty and Facility Care

The **Open Access High Level CPOS II Plan** provides you with the freedom to self-refer to any participating provider for any medically necessary services. When accessing a specialist the specialist copay will apply. Services from non-participating providers require prior approval from Aetna. When properly authorized, these services are covered in full after the applicable copayment or coinsurance.

For inpatient expenses and surgery performed in an outpatient facility, you must pay a portion of the covered expenses you incur. Your share of covered expenses is called your copayment. Once your copayments (excluding prescription drug copays) reach the annual payment limit maximum, the Plan pays 100% of your covered expenses for the remainder of that plan year.

Annual deductible

The annual deductible is the out-of-pocket expense you incur each plan year before Plan benefits begin. Separate deductibles apply to in-network and out-of-network expenses. Only expenses for covered services count toward satisfying your deductible. Expenses above the reasonable and customary limits set by Aetna are not counted. Co-pays do not count toward your deductible.

Family deductible

You and your covered dependents together will not have to meet more than the family deductible shown in the Summary of Benefits.

Payment Limit

This plan has an Individual Payment Limit. This means once the amount of eligible expenses you or your covered dependent have paid during the Plan Year meets the Individual Payment Limit, the plan will pay 100% of covered expenses for the remainder of the Plan Year for that person.

There is also a Family Payment Limit. This means once the amount of eligible expenses you or your covered dependent have paid during the Plan Year meets two times the Individual Payment Limit, the plan will pay 100% of covered expenses for the remainder of the Plan Year for all covered family members.

Expenses that do not apply to your payment limit – certain covered expenses do not apply toward your plan payment limit. These include:

- Charges over the recognized charge;
- Expenses incurred for outpatient prescription drugs;
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an urgent care provider;
- Mental health and substance abuse expenses covered by CIGNA & are not under the plan Aetna administers.

Provider Information

You may obtain, without charge, a listing of network providers from your Plan Administrator, by calling the toll-free Member Services number on your ID card.

It is easy to obtain information about providers in Aetna's network using the Internet. With DocFind® you can conduct an online search for participating doctors, hospitals and other providers. To use DocFind, go to **www.aetna.com/docfind**. Select the appropriate provider category and follow the instructions provided to select a provider based on specialty, geographic location and/or hospital affiliation. Make sure the provider participates in the CPOSII network for Aetna.

Your ID Card

When you join the Plan, you will receive ID cards for you and your family (if applicable). Always carry your ID card with you. It identifies you as a Plan participant when you receive services. When you obtain a prescription at a participating pharmacy, remember to present your ID card. If your card is lost or stolen, please notify Aetna immediately.

Requirements For Coverage

To be covered by the plan, services and supplies and prescription drugs must meet all of the following requirements:

1. The service or supply or prescription drug must be covered by the plan. For a service or supply or prescription drug to be covered, it must:
 - Be included as a covered expense in this Booklet;
 - Not be an excluded expense under this Booklet. Refer to the *Exclusions* sections of this Booklet for a list of services and supplies that are excluded;
 - Not exceed the maximums and limitations outlined in this Booklet. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
 - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet.
2. The service or supply or prescription drug must be provided while coverage is in effect. See the *Who Is Eligible to Join the Plan, Enrollment, Change in Status, When Coverage Ends and Continuation of Coverage* sections for details on when coverage begins and ends.
3. The service or supply or prescription drug must be medically necessary. To meet this requirement, the medical services, supply or prescription drug must be provided by a physician, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. The provision of the service or supply must be:
 - (a) In accordance with generally accepted standards of medical practice;
 - (b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

- (c) Not primarily for the convenience of the patient, physician or other health care provider;
- (d) And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Summary of Benefits

Below is a brief overview of some of the benefits available under the Plan. Refer to the sections entitled “Your Benefits” and “Exclusions and Limitations” for more detailed information.

All non-emergency hospital services require a prior referral from your physician.

TYPE OF SERVICE OR SUPPLY	IN NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	
Plan Year Deductible		
Individual	\$ 500	\$ 2,000
Family	\$ 1,000	\$ 4,000
Plan Year Payment Limit Maximum (excludes co-pays, prescription drugs, mental health and penalties)		
Individual	\$ 3,000	\$ 4,000
Family	\$ 6,000	\$ 8,000
Primary and Preventive Care		
PCP Office Visits	\$20 copay per visit	70% after deductible
Routine Adult Preventive Examinations, 1 per 12 months	100%, no copay	70% after deductible
Routine Child and Well-Baby Care, 7 exams in first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per 12 months to age 18.	100%, no copay	70% after deductible
Immunizations & Allergy Injections	100%, no copay	70% after deductible
Routine Gynecological Exams – one per 12 month period	100%, no copay	70% after deductible
Routine Mammogram – one per 12 month period (age 35 and older)	100%, no deductible	70% after deductible
Prostate Screening – one per 12 month period (age 40 and older)	100%, no copay	70% after deductible
Routine Eye Exam –one per 12 month period	100%, no copay	No benefit
Eyeglasses/Contact Lenses	Discounts available through Aetna Vision Discount Program	
Routine Hearing Screenings - one per 12-month period as part of wellness exam.	100%, no copay	No benefit
Hearing Aids	Discounts available through Arizona HearCare.	

Benefit Accumulators – Plan Year unless otherwise indicated.

Specialty and Outpatient Care		
Specialist Office Visits	\$40 copay per visit	70% after deductible
Prenatal Care	\$20 copay first visit	70% after deductible
Diagnostic X-rays and Lab Tests	90 % after deductible	70% after deductible
Therapy (speech, occupational, physical)-maximum 60 visits per plan year combined*	90% after deductible	70% after deductible
Chiropractic Care-maximum 20 visits per plan year, includes manipulations, evaluation and lab and x-ray.	90% after deductible	70% after deductible
Home Health Care-maximum 40 visits per plan year	90% after deductible	70% after deductible
Hospice Care	90% after deductible	70% after deductible
Durable Medical Equipment (DME)	90% after deductible – subject to a combined in-and out-of –network per member, per plan year maximum of \$10,000 – see page 17-18 for more information.	70% after deductible – subject to a combined in-and out-of-network per member, per plan year maximum of \$10,000 – see page 17-18 for more information.
Prosthetic Devices, some prostheses must be approved in advance by Aetna.	90% after deductible	70% after deductible

* Clinical Care Review (CCR) may be required for visits in excess of 25

Type of Service or Supply	In-network	Out-of-network
Inpatient Services		
Hospital Room and Board and Other Inpatient Services	90% after deductible	70% after deductible
Skilled Nursing Facilities –maximum 60 days per plan year	90% after deductible	70% after deductible
Transplants	Services covered by an Institute of Excellence (IOE) transplant facility are paid at 90% after deductible	Services at an Aetna contracted facility that is not an IOE transplant facility are paid at 70% after deductible
Hospice Facility	90% after deductible	70% after deductible
Surgery and Anesthesia		
Inpatient Surgery	90% after deductible	70% after deductible
Outpatient Surgery	90% after deductible	70% after deductible
Bariatric Surgery (pre-authorization required)	90% after deductible	70% after deductible
Mental and Nervous Conditions		
Inpatient Treatment through CIGNA Behavioral Health	90% after deductible.	
Outpatient Treatment through Aetna	\$40 co-pay	70% after deductible
Outpatient Treatment through CIGNA Behavioral Health	\$20 co-pay. All visits must be medically necessary.	
Residential and Partial Hospitalization	One day of inpatient care may be exchanged for two partial hospitalization sessions in lieu of hospitalization. Must be approved in advance by CIGNA Behavioral Health.	
Treatment of Alcohol and Drug Abuse		
Inpatient Detoxification through CIGNA Behavioral Health	90% after deductible	
Inpatient Rehabilitation through CIGNA Behavioral Health	90% after deductible	
Outpatient Detoxification through CIGNA Behavioral Health	\$20 co-pay. All visits must be medically necessary.	
Outpatient Detoxification through Aetna	\$40 co-pay	70% after deductible
Outpatient Rehabilitation through CIGNA Behavioral Health	\$20 co-pay. All visits must be medically necessary.	
Outpatient Rehabilitation through Aetna	\$40 co-pay	70% after deductible
Type of Service or Supply	In-network	Out-of-network
Emergency Care		
Emergency Room (copay waived if admitted)	\$150 copay/per visit +10% coinsurance after in-network deductible; no coverage for non-emergency use.	
Urgent Care	\$50 copay/per visit plus 10% coinsurance after in-network	70% after deductible

	deductible; no coverage for non-urgent use.	
Ambulance	90% after deductible	90% after deductible
Prescription Drugs	No annual maximum	
Retail (30-day supply)		
Generic drugs	\$10 copay	50% coinsurance
Brand name formulary drugs	20% coinsurance (\$30 min-\$50 max)	
Non-formulary drugs	40% coinsurance (\$50 min-\$100 max)	
Mail Order (90-day supply)		
Generic drugs	\$20 copay	No benefit
Brand name formulary drugs	\$60 copay	
Non-formulary drugs	\$110 copay	
Manadatory Generic (unless dispensed as written – DAW)		
If you choose a brand drug over an available generic drug, you will pay the generic co-pay plus the difference in cost between the brand drug and the generic drug. If your physician indicates that you must take the brand drug over the generic, then you will just pay the applicable brand drug co-pay.		

Your Benefits

Although a specific service may be listed as a covered benefit, it may not be covered unless it is **medically necessary** for the prevention, diagnosis or treatment of your illness or condition. Refer to the “Glossary” section for the definition of “medically necessary.”

Certain services must be precertified by Aetna. You or your participating provider is responsible for obtaining this approval.

Routine Physical Exams

Covered expenses include charges made by your primary care physician for routine physical exams. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- Radiological services, X-rays, lab and other tests given in connection with the exam; and
- Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control; and
- Testing for Tuberculosis.

Covered expenses for children from birth to age 18 also include:

- An initial hospital check up and well child visits in accordance with the prevailing clinical standards of the American Academy of Pediatric Physicians.

Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this plan;
- Services which are for diagnosis or treatment of a suspected or identified illness or injury;
- Exams given during your stay for medical care;
- Services not given by a physician or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;
- Services and supplies furnished by an out-of-network provider.

Routine Cancer Screenings

Covered expenses include charges incurred for routine cancer screening as follows:

- 1 mammogram every 12 months for covered females age 35 and over, if prescribed by a physician
- 1 mammogram every 12 months for covered females age 40 and over
- 1 Pap smear every 12 months;
- 1 gynecological exam every 12 months;
- 1 fecal occult blood test every 12 months; and
- 1 digital rectal exam and 1 prostate specific antigen (PSA) test every 12 months for covered males age 40 and older.

The following tests are covered expenses if you are age 50 and older when recommended by your physician:

- 1 Sigmoidoscopy every 5 years for persons at average risk; *or*
- 1 Double contrast barium enema (DCBE) every 5 years for persons at average risk; *or*
- 1 Colonoscopy every 10 years for persons at average risk for colorectal cancer.

Hearing Exam

Covered expenses include charges for an audiometric hearing exam if the exam is performed by:

- A physician certified as an otolaryngologist or otologist; or
- An audiologist who:
 - Is legally qualified in audiology; or
 - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and
 - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

The plan will not cover expenses for charges for more than one hearing exam for any 12-month period.

- All covered expenses for the hearing exam are subject to any applicable deductible, copay and payment percentage shown in your *Summary of Benefits*.

Specialty and Outpatient Care

The Plan covers the following specialty and outpatient services.

- Participating specialist office visits.
- Participating specialist consultations, including second opinions.
- Outpatient surgery for a covered surgical procedure.
- Preoperative and postoperative care.
- Casts and dressings.
- Radiation therapy.
- Cancer chemotherapy.
- Short-term speech, occupational (except vocational rehabilitation and employment counseling), and physical therapy for treatment of non-chronic conditions and acute illness or injury-up to a combined 60 visits per plan year. Upon reaching 25 visits, you may be required to provide clinical information and a treatment plan to Aetna in order for continued visits to be approved under the Plan. The clinical information is provided by your health care provider to Aetna and contains information reflecting the measureable improvement of your therapy.
- Cognitive therapy associated with physical rehabilitation for treatment of non-chronic conditions and acute illness or injury.
- Short-term cardiac rehabilitation provided on an outpatient basis following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Short-term pulmonary rehabilitation provided on an outpatient basis for the treatment of reversible pulmonary disease.
- Diagnostic, laboratory and X-ray services.

- Emergency care including ambulance service - 24 hours a day, 7 days a week (see “In Case of Emergency”). Air transport is also a covered expense when medically necessary and when transport is to the nearest participating facility.
- Home health services provided by a participating home health care agency up to 40 visits per plan year, including:
 - skilled nursing services provided or supervised by an RN.
 - services of a home health aide for skilled care.
 - medical social services provided or supervised by a qualified physician or social worker if your physician certifies that the medical social services are necessary for the treatment of your medical condition.
- Covered hospice services for a Plan participant who is terminally ill, including:
 1. Inpatient care in a covered hospice care facility, hospital or convalescent facility
 2. All standard covered home health care services provided by a Hospice Care Agency, such as:
 - Part-time or intermittent nursing care by a registered graduate nurse (R.N.) or licensed practical nurse (L.P.N.) for up to 8 hours in any one day.
 - Medical social services, under the direction of a physician, which include:
 - Assessment of the family member's social, emotional and medical needs, and the home and family situation.
 - Identification of the community resources which are available to the family member.
 - Assisting the family member to obtain those resources needed to meet the family member's assessed needs.
 - Psychological and dietary counseling.
 - Consultation or case management services by a physician.
 - Physical and occupational therapy.
 - Part-time or intermittent home health aide services, for up to 8 hours in any one day, which consist mainly of caring for the family member. (Note: Home Health Care benefits can be used to supplement hospice home health aide hours to a combined maximum of 50 hours per week. Additional hours are the responsibility of the member, although skilled nursing facility placement can be considered if more than these hours are needed).
 - Medical supplies, drugs, and medicines prescribed by a physician.
 3. Physician services for consultation and case management.
- The Plan covers physician's fees for dental services related to an accidental injury in which the jaw is broken or the natural teeth are injured.
- The Plan covers surgery needed to:
 - treat a fracture, dislocation or wound.
 - cut out:
 - Teeth partly or completely impacted in the jaw bone;
 - Teeth that will not erupt through the gum;
 - Other teeth that can't be removed without cutting into the bone;
 - The roots of a tooth without removing the entire tooth; or
 - Cysts, tumors or other diseased tissues.

- cut into gums and tissues of the mouth. This is covered only when it's done in connection with the removal, replacement or repair of teeth.
- change the jaw, jaw joints or bite relationships using a cutting procedure when appliance therapy alone can't improve function.

Note: Benefits for preceding services are provided on a secondary basis compared to any dental benefit coverage in effect.

- Reconstructive breast surgery following a mastectomy, including:
 - reconstruction of the breast on which the mastectomy is performed, including areolar reconstruction and the insertion of a breast implant,
 - surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed, and
- Bariatric Surgery (Must be Pre-Authorized)
 - Covers Roux-en-Y Gastric Bypass (RYGB), Laparoscopic Adjustable Silicone Gastric Banding (LASGB), Biliopancreatic Diversion (BPD) Vertical Banded Gastroplasty, and Duodenal Switch (DS) procedures when all Aetna criteria are met.
 - Covers repeat Bariatric Surgery when Aetna considers medically necessary for members who met medical necessity criteria for their initial bariatric surgery
 - Weight loss surgery is reserved for a limited number of adults whose obesity is severe, is refractory to other medical treatments, and is intended for morbidly obese patients who have failed other therapeutic approaches to weight reduction.
- Infertility services to diagnose and treat the underlying medical cause of infertility.
 - initial evaluation, including history, physical exam and laboratory studies performed at an appropriate participating laboratory,
 - evaluation of ovulatory function,
 - ultrasound of ovaries at an appropriate participating radiology facility,
 - postcoital test,
 - hysterosalpingogram,
 - endometrial biopsy, and
 - hysteroscopy
 - oral fertility medication
 - semen analysis at an appropriate participating laboratory is covered for male Plan participants.
- Chiropractic services (20 visits per plan year). Subluxation services must be consistent with Aetna's guidelines for spinal manipulation to correct a muscular skeletal problem or subluxation that could be documented by diagnostic X-rays performed by a participating radiologist.
- Prosthetic appliances and orthopedic braces (including repair and replacement when due to normal growth).
- Orthotics
- Durable medical equipment (DME)

Covered Equipment

Covered equipment replaces body function lost or impaired due to a disease, injury or congenital abnormality, or must be medically necessary to enable the patient to perform essential activities of daily living within and outside the home, related to the patient's health and hygiene (with minimal or no assistance from others).

Exception: It does not include equipment to enable someone to drive a vehicle or be transported in a vehicle, or equipment solely for the convenience of the patient's caretaker.

Covered equipment is:

- not aesthetic in nature (basic cane compared to a hand-carved cane)
- less costly than alternative equipment (standard electric wheelchair vs. super deluxe wheelchair, when the standard chair is effective)
- used to serve a medical purpose and not useful in the absence of disease or injury, and not be used to enhance the patient's home or environment, alter air quality or temperature or for exercise or training
- made to withstand prolonged and repeated use. Expendable supplies may also be covered when required to operate durable medical equipment and prosthetic devices or when needed for medically necessary therapy in the home, and
- appropriate for home use - is safe and effective for use without medical supervision.

Repair and Maintenance

The Plan will cover charges for a repair service or maintenance agreement purchased at the time durable medical equipment is purchased, and/or necessary repairs and maintenance of purchased DME. Note: If a plan does not cover the purchase of the initial item, it would not cover maintenance or repair.

Replacement

The Plan will cover charges for replacement of purchased equipment when it cannot be repaired or repairs would be more expensive than purchasing or renting replacement equipment, or replacement is recommended by the attending physician because of a change in the patient's physical condition.

Examples: Replacement wheelchair, replacement hospital bed, replacement walker.

Shipping Postage or Delivery Charges

The Plan will cover reasonable and appropriate charges for shipping, mailing or delivering covered durable medical equipment: as part of the initial monthly rental fee, or if purchase is approved as part of the purchase price. Example: Shipping charges submitted for \$25. Purchase price of DME item is \$150. Negotiated rate for DME item is \$125. The Plan would not allow any additional for shipping as shipping is included as part of purchase price.

- Depo-Provera injections – up to 5 vials in a consecutive 365-day period.
- Varicose Vein Treatments may be covered if certain conditions exist. Please be sure to contact member services to review covered procedures.
- Temporomandibular joint (TMJ) – All TMJ surgical precertification requests or claims must be reviewed by the Aetna Oral and Maxillofacial Surgery (OMS) Patient Management Unit. If the treatment is considered experimental and investigational for diagnosis and treatment of TMJ disorders, the procedure will not be covered by the plan.

Inpatient Care in a Hospital, Skilled Nursing Facility or Hospice

Hospital Expenses

Covered medical expenses include services and supplies provided by a **hospital** during your **stay**.

Room and Board

Covered expenses include charges for room and board provided at a hospital during your stay. Private room charges that exceed the hospital's semi-private room rate are not covered unless a private room is required because of a contagious illness or immune system problem.

Room and board charges also include:

- Services of the hospital's nursing staff;
- Admission and other fees;
- General and special diets; and
- Sundries and supplies.

Transplant Services

Covered expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your dependents may require an organ transplant. Organ means solid organ; stem cell; bone marrow; and tissue.

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;
- Intestine;
- Bone Marrow/Stem Cell;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (Stem Cell);
- Sequential transplants;
- Re-transplant of same organ type within 180 days of the first transplant;
- Any other single organ transplant, unless otherwise excluded under the plan.

The following will be considered to be *more than one* Transplant Occurrence:

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant);
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant);
- Re-transplant after 180 days of the first transplant;
- Pancreas transplant following a kidney transplant;

- A transplant necessitated by an additional organ failure during the original transplant surgery/process;
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

The network level of benefits is paid only for a treatment received at a facility designated by the plan as an **Institute of Excellence™ (IOE)** for the type of transplant being performed. Each **IOE** facility has been selected to perform only certain types of transplants.

Services obtained from a facility that is not designated as an **IOE** for the transplant being performed will be covered as out-of-network services and supplies, even if the facility is a network facility or **IOE** for other types of services.

The plan covers:

- Charges made by a physician or transplant team.
- Charges made by a hospital, outpatient facility or physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.
- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an “immediate” family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant; *or* upon the date you are discharged from the hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility’s transplant program;
2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;

3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement; and
4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

If you are a participant in the **IOE** program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any covered expenses you incur from an **IOE** facility will be considered network care expenses.

Limitations

Unless specified above, *not* covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not covered under this plan;
- Home infusion therapy after the transplant occurrence;
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness;
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Aetna.

Network of Transplant Specialist Facilities

Through the **IOE** network, you will have access to a provider network that specializes in transplants. Benefits may vary if an **IOE** facility or non-**IOE** or out-of-network provider is used. In addition, some expenses are payable only within the **IOE** network. The **IOE** facility must be specifically approved and designated by Aetna to perform the procedure you require. Each facility in the **IOE** network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

Other Hospital Services and Hospice

Covered expenses include charges made by a hospital for services and supplies furnished to you in connection with your stay.

Covered expenses include hospital charges for other services and supplies provided, such as:

- Ambulance services.
- Physicians and surgeons.
- Operating and recovery rooms.
- Intensive or special care facilities.
- Administration of blood and blood products, but not the cost of the blood or blood products.
- Radiation therapy.

- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.

Birth Center

Covered expenses include charges made by a birth center for services and supplies related to your care in a birth center for:

- Prenatal care;
- Delivery; and
- Postpartum care within 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery.

Limitations

Unless specified above, not covered under this benefit are charges:

- In connection with a pregnancy for which pregnancy related expenses are not included as a covered expense.

See *Maternity* for information about other covered expenses related to maternity care.

Skilled Nursing Facility

Covered expenses include charges made by a skilled nursing facility during your stay for the following services and supplies, up to the maximums shown in the *Schedule of Benefits*, including:

- Room and board, up to the semi-private room rate. The plan will cover up to the private room rate if it is needed due to an infectious illness or a weak or compromised immune system;
- Use of special treatment rooms;
- Radiological services and lab work;
- Physical, occupational, or speech therapy;
- Oxygen and other gas therapy;
- Other medical services and general nursing services usually given by a skilled nursing facility (this does not include charges made for private or special nursing, or physician's services); and
- Medical supplies.

Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Charges made for the treatment of:
 - Drug addiction;
 - Alcoholism;
 - Senility;
 - Mental retardation; or

- Any other mental illness; and
- Daily room and board charges over the semi private rate.

Hospice Care

Covered expenses include charges made by the following furnished to you for hospice care when given as part of a hospice care program.

Facility Expenses

The charges made by a hospital, hospice or skilled nursing facility for:

- Room and Board and other services and supplies furnished during a stay for pain control and other acute and chronic symptom management; and
- Services and supplies furnished to you on an outpatient basis.

Outpatient Hospice Expenses

Covered expenses include charges made on an outpatient basis by a Hospice Care Agency for:

- Part-time or intermittent nursing care by a R.N. or L.P.N. for up to eight hours a day;
- Part-time or intermittent home health aide services to care for you up to eight hours a day.
- Medical social services under the direction of a physician. These include but are not limited to:
 - Assessment of your social, emotional and medical needs, and your home and family situation;
 - Identification of available community resources; and
 - Assistance provided to you to obtain resources to meet your assessed needs.
- Physical and occupational therapy; and
- Consultation or case management services by a physician;
- Medical supplies;
- Prescription drugs;
- Dietary counseling; and
- Psychological counseling.

Charges made by the providers below if they are not an employee of a Hospice Care Agency; and such Agency retains responsibility for your care:

- A physician for a consultation or case management;
- A physical or occupational therapist;
- A home health care agency for:
 - Physical and occupational therapy;
 - Part time or intermittent home health aide services for your care up to eight hours a day;
 - Medical supplies;
 - Prescription drugs;
 - Psychological counseling; and
 - Dietary counseling.

Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Daily room and board charges over the semi-private room rate.
- Bereavement counseling.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. This includes estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.
- Respite care. This is care furnished during a period of time when your family or usual caretaker cannot attend to your needs.

Maternity

The Plan covers physician and hospital care for mother and baby, including prenatal care, delivery and postpartum care. In accordance with the Newborns' and Mothers' Health Protection Act, you and your newly born child are covered for a minimum of 48 hours of inpatient care following a vaginal delivery (96 hours following a cesarean section). However, your provider may – after consulting with you – discharge you earlier than 48 hours after a vaginal delivery (96 hours following a cesarean section).

Note: You or your participating obstetrician is responsible for obtaining precertification from Aetna for all obstetrical care.

If you are pregnant at the time you join the Plan, you receive coverage for authorized care on and after your effective date. There is no waiting period. Coverage for services incurred prior to your effective date with the Plan are your responsibility or that of your previous plan.

Behavioral Health & Substance Abuse

Please note that all in-patient care is provided by CIGNA Behavioral Health (CBH) and requires pre-authorization. CBH also provides the highest level of coverage for out-patient care when using CBH participating providers. Aetna provides out-patient coverage only for members who do not use CBH participating providers. Please call the Employee Assistance Program (EAP) first as you may be eligible for five free out-patient visits before transitioning to the coverage provided by the medical plans.

Your mental health/substance abuse benefits will be provided by participating behavioral health providers (CBH if in-patient and CBH or Aetna if out-patient). When you need mental health or substance abuse treatment, call the behavioral health telephone number shown on your ID card. A clinical care manager will assess your situation and refer you to participating providers, as needed.

Treatment of Mental or Nervous Conditions

The Plan covers the following services for mental health treatment:

- Inpatient medical, nursing, counseling and therapeutic services in a hospital or non-hospital residential facility, appropriately licensed by the Department of Health or its equivalent.
- Short-term evaluation and crisis intervention mental health services provided on an outpatient basis.

When precertified by CIGNA Behavioral Health, one day of inpatient treatment may be substituted for four outpatient visits, up to a maximum of 10 inpatient days/40 outpatient visits. One day of inpatient treatment may be substituted for two days of partial hospitalization, if approved by CIGNA Behavioral Health.

Treatment of Alcohol and Drug Abuse

- Inpatient care for detoxification, including medical treatment and referral services for substance abuse or addiction.
- Inpatient medical, nursing, counseling and therapeutic rehabilitation services for treatment of alcohol or drug abuse or dependency in a hospital or non-hospital residential facility, appropriately licensed by the Department of Health or its equivalent, upon referral by your provider.
- Outpatient visits for substance abuse detoxification. Benefits include diagnosis, medical treatment and medical referral services by your physician.
- Outpatient visits to a behavioral health provider for diagnostic, medical or therapeutic rehabilitation services for substance abuse.
- Outpatient treatment for substance abuse or dependency must be provided in accordance with an individualized treatment plan.

Employee Assistance Program (Provided through CIGNA Behavioral Health)

The Employee Assistance Program (EAP) helps you balance work with family needs, deal with personal problems, and improve your overall performance and quality of life. The EAP includes:

- Free consultation by telephone, or up to five face-to-face sessions per issue, per 12-month period for behavioral health issues
- Information and referrals for child care, elder care, adoption and more
- Immediate assistance for critical emotional needs
- Guidance for finding local resources

These services can be accessed 24-hours a day, 7-days a week by contacting Cigna Behavioral Health toll-free at 1-800-554-6931.

Prescription Drugs

The Plan pays, subject to any limitations specified under “Your Benefits,” the cost incurred for outpatient prescription drugs that are obtained from an in-network or out-of-network pharmacy. You must present your ID card and make the copayment shown in the “Summary of Benefits” for each prescription at the time the prescription is dispensed.

The Plan covers the costs of prescription drugs, in excess of the copayment, that are:

- Medically necessary for the care and treatment of an illness or injury, as determined by Aetna;

- Prescribed in writing by a physician who is licensed to prescribe federal legend prescription drugs or medicines; and
- Not listed below under “Prescription Drug Exclusions and Limitations.”

Each retail prescription is limited to a maximum 30-day supply, with refills as authorized by your physician (but not to exceed one year from the date originally prescribed). Non-emergency prescriptions must be filled at a participating pharmacy. Generic drugs may be substituted for brand-name products where permitted by law.

Coverage is based upon Aetna’s formulary. The formulary includes both brand name and generic drugs and is designed to provide access to quality, affordable outpatient prescription drug benefits. You can reduce your copayment by using a covered generic drug or a covered brand-name drug that appears on the formulary. Your copayment will be highest if your physician prescribes a covered brand-name drug that does not appear on the formulary.

Important Note Concerning Generic Drug Usage

If you choose a brand drug over an available generic drug, you will pay the generic co-pay plus the difference in cost between the brand drug and the generic drug. If your physician indicates that you must take the brand drug over the generic, then you will just pay the applicable brand drug co-pay.

Medicare Part D and your Prescription Drug Plan

If you and/or your dependent(s) are enrolled in either Part A or B of Medicare, you are also eligible for Medicare Part D Prescription Drug benefits. It has been determined that the prescription drug coverage outlined in this document is “creditable.” “Creditable” means that the value of this Plan’s prescription drug benefit is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

Because this Plan’s prescription drug coverage is as good as Medicare, you do not need to enroll in a Medicare Prescription Drug Plan in order to avoid a late penalty under Medicare. You may, in the future, enroll in a Medicare Prescription Drug Plan during Medicare’s annual enrollment period (November 15 through December 31 of each year).

Mail Order Drugs

Participants in the Plan who must take a drug for more than 30 days may obtain up to a 90-day supply of the drug at a participating mail order pharmacy, if authorized by their physician. The minimum quantity dispensed by a mail order pharmacy is for a 31-day supply, and the maximum quantity is for a 90-day supply. The copayment shown in the “Summary of Benefits” will apply to each mail order purchase.

Covered Drugs

The Plan covers the following:

- Outpatient prescription drugs when prescribed by a physician who is licensed to prescribe federal legend drugs or medicines, subject to the terms, limitations and exclusions described in this booklet.

- FDA-approved prescription drugs when the off-label use of the drug has not been approved by the FDA to treat the condition in question, provided that:
 - the drug is recognized for treatment of the condition in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information), or
 - the safety and effectiveness of use for the condition has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal.
 - diabetic needles and syringes
 - alcohol swabs.
 - test strips for glucose monitoring and/or visual reading.
 - diabetic test agents.
 - lancets (and lancing devices)
 - oral contraceptives. Depo-Provera injections are covered under specialty and outpatient care.
 - one diaphragm per 365-day period.
 - implantable contraceptives (such as Norplant) and IUDs are covered when obtained from your physician or participating Ob/Gyn. The office visit copayment will apply when the device is inserted and removed.
- Drugs prescribed to aid or enhance lifestyle/performance, including sildenafil citrate, phentolamine, apomorphine and alprostadil in oral and topical (including but not limited to gels, creams, ointments and patches) forms. Coverage is limited to a total of no more than seven pills or other forms (in unit amounts determined by Aetna to be similar in cost to oral forms) per 30-day supply. Mail order supplies are not covered.
- Oral Fertility Drugs.

Prescription Drug Exclusions and Limitations

Prescription Drug Exclusions

These prescription drug exclusions are in addition to the exclusions listed under your medical coverage.

The plan does not cover the following expenses:

Administration or injection of any drug.

Any charges in excess of the benefit, dollar, day, or supply limits stated in this Booklet.

Allergy sera and extracts.

Any non-emergency charges incurred outside of the United States 1) if you traveled to such location to obtain prescription drugs, or supplies, even if otherwise covered under this Booklet, or 2) such drugs or supplies are unavailable or illegal in the United States, or 3) the purchase of such prescription drugs or supplies outside the United States is considered illegal.

Any drugs or medications, services and supplies that are not medically necessary, as determined by Aetna, for the diagnosis, care or treatment of the illness or injury involved. This applies even if they are prescribed, recommended or approved by your physician or dentist.

Biological sera, blood, blood plasma, blood products or substitutes or any other blood products.

Contraception:

- Over the counter contraceptive supplies including but not limited to: condoms, contraceptive foams, jellies and ointments; and
- Services associated with the prescribing, monitoring and/or administration of contraceptives.

Cosmetic drugs, medications or preparations used for cosmetic purposes or to promote hair growth, including but not limited to health and beauty aids, chemical peels, dermabrasion, treatments, bleaching, creams, ointments or other treatments or supplies, to remove tattoos, scars or to alter the appearance or texture of the skin.

Drugs administered or entirely consumed at the time and place it is prescribed or dispensed.

Drugs which do not, by federal or state law, require a prescription order (i.e. over-the-counter (OTC) drugs), even if a prescription is written.

Drugs provided by, or while the person is an inpatient in, any healthcare facility; or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it.

Drugs used primarily for the treatment of infertility, or for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, except as described in the *What the Plan Covers* section.

Drugs used for the purpose of weight gain or reduction, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications.

Drugs used for the treatment of obesity.

All drugs or medications in a therapeutic drug class if one of the drugs in that therapeutic drug class is not a prescription drug.

Durable medical equipment, monitors and other equipment.

Experimental or investigational drugs or devices, except as described in the *Summary of Benefits* section.

This exclusion will not apply with respect to drugs that:

- Have been granted treatment investigational new drug (IND); or Group c/treatment IND status; or
- Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and
- Aetna determines, based on available scientific evidence, are effective or show promise of being effective for the illness.

Food items: Any food item, including infant formulas, nutritional supplements, vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.

Genetics: Any treatment, device, drug, or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.

Immunization or immunological agents.

Implantable drugs and associated devices.

Injectables:

- Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by the Plan;
- Needles and syringes, except for diabetic needles and syringes;
- Injectable drugs if an alternative oral drug is available.

Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps.

Prescription drugs for which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a prescription is written.

Prescription drugs, medications, injectables or supplies provided through a third party vendor contract with the contractholder.

Prescription orders filled prior to the effective date or after the termination date of coverage under this Booklet.

Prophylactic drugs for travel.

Refills in excess of the amount specified by the prescription order. Before recognizing charges, Aetna may require a new prescription or evidence as to need, if a prescription or refill appears excessive under accepted medical practice standards.

Refills dispensed more than one year from the date the latest prescription order was written, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.

Replacement of lost or stolen prescriptions.

Drugs, services and supplies provided in connection with treatment of an occupational injury or occupational illness.

Smoking: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum.

Strength and performance: Drugs or preparations, devices and supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids.

Sex change: Any treatment, drug or supply related to changing sex or sexual characteristics, including hormones and hormone therapy.

Sexual dysfunction/enhancement: Any drug, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ.

Supplies, devices or equipment of any type, except as specifically provided in the *What the Plan Covers* section.

Test agents except diabetic test agents.

Prescription Drug Limitations

The following limitations apply to the prescription drug coverage:

- A retail or mail order pharmacy may refuse to fill a prescription order or refill when, in the professional judgment of the pharmacist, the prescription should not be filled.
- To receive the in-network level of benefits, prescriptions may be filled only at a participating retail or mail order pharmacy, except in the event of emergency or urgent care. Aetna will not reimburse Plan participants for out-of-pocket prescription purchases from either a participating or non-participating pharmacy in non-emergency, non-urgent care situations.
- Plan participants must present their ID cards at the time each prescription is filled to verify coverage. If you do not present your ID card, your purchase may not be covered by the Plan, except in emergency and urgent care situations, and you may be required to pay the entire cost of the prescription.
- Refill too soon edits: Aetna's standard refill parameters are shown below. The parameters are in place to deal with members who will need to order a refill early when going on vacation, etc. But if a member orders a refill too early on a consistent basis, the system will eventually recognize this and the Cumulative Refill Too Soon edit will apply. The purpose of this edit is to identify potential situations where prescriptions are being filled before they are needed in order to “stockpile” medications because of anticipated termination of coverage or other event or to identify potential situations where medication is being taken inconsistent with the physician’s orders that could result in an over-utilization of medications.

Retail

For scripts written for a nine day supply or less, a refill will process when 50% of the medication is used.

For scripts written for more than a nine day supply, a refill will process when 75% of the medication is used.

Mail order

For scripts written for up to a 30 day supply, a refill will process when 50% of the medication is used.

For scripts written for a 31 to a 60 day supply, a refill will process when 60% of the medication is used.

For scripts written for a 61 to a 90 day supply, a refill will process when 66% of the medication is used.

Exclusions and Limitations

Exclusions

Not every medical service or supply is covered by the plan, even if prescribed, recommended or approved by your physician or dentist.

The Plan does not cover the following services and supplies:

Acupuncture, acupressure and acupuncture therapy, except as provided in the *Summary of Benefits* section.

Allergy: Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity, and urine autoinjections.

Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Booklet.

Any non-emergency charges incurred outside of the United States 1) if you traveled to such location to obtain prescription drugs, or supplies, even if otherwise covered under this Booklet, or 2) such drugs or supplies are unavailable or illegal in the United States, or 3) the purchase of such prescription drugs or supplies outside the United States is considered illegal.

Applied Behavioral Analysis, the LEAP, TEACCH, Denver and Rutgers programs.

Behavioral Health Services:

- Alcoholism or substance abuse rehabilitation treatment on an inpatient or outpatient basis, except to the extent coverage for detoxification or treatment of alcoholism or substance abuse is specifically provided in the *Summary of Benefits* Section.
- Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field.
- Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.
- Treatment of antisocial personality disorder.
- Treatment in wilderness programs or other similar programs.
- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded in accordance with the benefits provided in the *Summary of Benefits* section of this Booklet.

Charges for a service or supply furnished by a network provider in excess of the negotiated charge.

Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan.

Charges submitted for services by an unlicensed hospital, physician or other provider or not within the scope of the provider's license.

Contraception, except as specifically described in the *Summary of Benefits* Section:

- Over the counter contraceptive supplies including but not limited to condoms, contraceptive foams, jellies and ointments.

Cosmetic services and plastic surgery: any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:

- Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
- Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
- Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when **medically necessary**;
- Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy); and
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- Surgery to correct Gynecomastia;
- Breast augmentation;
- Otoplasty.

Counseling: Services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor.

Court ordered services, including those required as a condition of parole or release.

Custodial Care

Dental Services: any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:

- services of dentists, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
- dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
- non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors and orthodontogenic cysts.

Disposable outpatient supplies: Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.

Drugs, medications and supplies:

- Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a prescription including vitamins;
- Any services related to the dispensing, injection or application of a drug;
- Any prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
- Immunizations related to work;
- Needles, syringes and other injectable aids, except as covered for diabetic supplies;
- Drugs related to the treatment of non-covered expenses;
- Performance enhancing steroids;
- Injectable drugs if an alternative oral drug is available;
- Any expenses for prescription drugs, and supplies covered under an Aetna Pharmacy plan will not be covered under this medical expense plan. Prescription drug exclusions that apply to the Aetna Pharmacy plan will apply to the medical expense coverage.

Educational services:

- Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
- Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause; and
- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

Examinations:

- Any health examinations:
 - required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
 - required by any law of a government, securing insurance or school admissions, or professional or other licenses;
 - required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
 - any special medical reports not directly related to treatment except when provided as part of a covered service.

Experimental or investigational drugs, devices, treatments or procedures, except as described in the *Summary of Benefits* section.

Facility charges for care services or supplies provided in:

- rest homes;
- assisted living facilities;
- similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
- health resorts;
- spas, sanitariums; or
- infirmaries at schools, colleges, or camps.

Food items: Any food item, including infant formulas, nutritional supplements, vitamins, including prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.

Foot care: Any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:

- treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
- Shoes (including orthopedic shoes), arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an illness or injury.

Growth/Height: Any treatment, device, service or supply (including surgical procedures and devices to stimulate growth), solely to increase or decrease height or alter the rate of growth.

Hearing:

- Any hearing service or supply that does not meet professionally accepted standards;
- Hearing exams given during a stay in a hospital or other facility; and
- Any tests, appliances, and devices for the improvement of hearing (including hearing aids and amplifiers), or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech.

Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:

- Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds, and swimming pools;
- Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices;
- Equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs;
- Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
- Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
- Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your illness or injury;
- Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or illness; and
- Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

Home births: Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

Infertility: except as specifically described in the *What the Plan Covers* Section, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:

- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
- Artificial Insemination;
- Any advanced reproductive technology (“ART”) procedures or services related to such procedures, including but not limited to in vitro fertilization (“IVF”), gamete intra-fallopian transfer (“GIFT”), zygote intra-fallopian transfer (“ZIFT”), and intra-cytoplasmic sperm injection (“ICSI”); Artificial Insemination for covered females attempting to become pregnant who are not infertile as defined by the plan;
- Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Procedures, services and supplies to reverse voluntary sterilization;

- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Home ovulation prediction kits or home pregnancy tests;
- Any charges associated with care required to obtain ART Services (e.g., office, hospital, ultrasounds, laboratory tests); and any charges associated with obtaining sperm for any ART procedures; and
- Ovulation induction and intrauterine insemination services if you are not infertile.

Medicare: Payment for that portion of the charge for which Medicare or another party is or upon proper application would be the primary payer.

Miscellaneous charges for services or supplies including:

- Annual or other charges to be in a physician's practice;
- Charges to have preferred access to a physician's services such as boutique or concierge physician practices;
- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
 - Care in charitable institutions;
 - Care for conditions related to current or previous military service;
 - Care while in the custody of a governmental authority;
 - Any care a public hospital or other facility is required to provide; or
 - Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

Non-medically necessary services, including but not limited to, those treatments, services, prescription drugs and supplies which are not medically necessary, as determined by Aetna, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist.

Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including: Telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

Sex change: Any treatment, drug, service or supply related to changing sex or sexual characteristics, including:

- Surgical procedures to alter the appearance or function of the body;
- Hormones and hormone therapy;
- Prosthetic devices; and
- Medical or psychological counseling.

Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member.

Services of a resident physician or intern rendered in that capacity.

Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.

Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
- Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.

Smoking: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum.

Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued under the *Continuation of Coverage* section of this Booklet.

Services that are not covered under this Booklet.

Services and supplies provided in connection with treatment or care that is not covered under the plan.

Speech therapy for treatment of delays in speech development, except as specifically provided in the *Summary of Benefits*. For example, the plan does not cover therapy when it is used to improve speech skills that have not fully developed.

Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:

- Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;
- Drugs or preparations to enhance strength, performance, or endurance; and
- Treatments, services and supplies to treat illnesses, injuries or disabilities related to the use of performance-enhancing drugs or preparations.

Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-

covered diagnoses include Pervasive Developmental Disorders (including Autism), Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

Therapies and tests: Any of the following treatments or procedures:

- Aromatherapy;
- Bio-feedback and bioenergetic therapy;
- Carbon dioxide therapy;
- Chelation therapy (except for heavy metal poisoning);
- Computer-aided tomography (CAT) scanning of the entire body;
- Educational therapy;
- Gastric irrigation;
- Hair analysis;
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

Transplant-The transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services and supplies furnished to a donor when recipient is not a covered person;
- Home infusion therapy after the transplant occurrence;
- Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness;
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise precertified by Aetna.

Transportation costs, including ambulance services for routine transportation to receive outpatient or inpatient services except as described in the *Summary of Benefits* section.

Unauthorized services, including any service obtained by or on behalf of a covered person without Precertification by Aetna when required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation.

Vision-related services and supplies, except as described in the *Summary of Benefits* section. The plan does not cover:

- Special supplies such as non-prescription sunglasses and subnormal vision aids;
- Vision service or supply which does not meet professionally accepted standards;
- Eye exams during your stay in a hospital or other facility for health care;
- Eye exams for contact lenses or their fitting;
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
- Replacement of lenses or frames that are lost or stolen or broken;
- Acuity tests;
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
- Services to treat errors of refraction.

Work related: Any illness or injury related to employment or self-employment including any illness or injury that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered "non-occupational" regardless of cause.

Limitations

In the event there are two or more alternative medical services that, in the sole judgment of the Plan Administrator or its designee are equivalent in quality of care, the Plan reserves the right to cover only the least costly service, as determined by the Plan Administrator or its designee, provided that the Plan or its designee approves coverage for the service or treatment in advance. If you wish to view more clinical information as to why certain procedures are covered or excluded, or if there are certain requirements prior to the procedure, you can go to Aetna.com and look up Clinical Policy Bulletins.

In Case of Emergency

Guidelines

If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. The Plan has adopted the following definition of an emergency medical condition from the Balanced Budget Act (BBA) of 1997:

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- *Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;*

- *Serious impairment to bodily function; or*
- *Serious dysfunction of any bodily organ or part.*

Some examples of emergencies are:

- | | |
|---|---------------------------------------|
| - Heart attack or suspected heart attack. | - Suspected overdose of medication. |
| - Poisoning. | - Severe burns. |
| - Severe shortness of breath. | - High fever (especially in infants). |
| - Uncontrolled or severe bleeding. | - Loss of consciousness. |

Whether you are in or out of Aetna's service area, we ask that you follow the guidelines below when you believe you may need emergency care.

1. Call your physician first, if possible. However, if a delay would be detrimental to your health, seek the nearest emergency facility or dial 911 emergency response services.
2. After assessing and stabilizing your condition, the emergency facility should contact your physician so they can assist the treating physician by supplying information about your medical history.
3. If you or a covered family member receives emergency services outside of the Aetna service area, you or a family member must notify Aetna (at the telephone number shown on your identification card) as soon as possible, or within 48 hours.
4. If you are admitted to an inpatient facility, notify your physician as soon as reasonably possible. The emergency room copayment will be waived if you are admitted to the hospital.
5. All follow-up care must be coordinated by your physician.
6. If you go to an emergency facility for treatment that Aetna determines is non-emergency in nature, you will be responsible for the bill. The Plan does not cover non-emergency use of the emergency room.

Coverage for emergency care in the emergency room is shown in the Summary of Benefits.

Follow-Up Care After Emergencies

All follow-up care should be coordinated by a participating physician. You must have approval from Aetna to receive follow-up care from a nonparticipating provider. Suture removal, cast removal, X-rays, and clinic and emergency room revisits are some examples of follow-up care.

Urgent Care

Treatment that you obtain for an urgent medical condition is covered if:

- The service is a covered benefit; and
- A delay in receiving care would have caused serious deterioration in your health.

Some examples of urgent medical conditions are:

- | | |
|--------------------|----------------|
| - Severe vomiting. | - Sore throat. |
| - Earaches. | - Fever. |

Follow-up care provided by a participating provider is covered, subject to the office visit copayment. Coverage for urgent care conditions is shown in the Summary of Benefits.

Special Programs

Alternative Health Care Programs

Natural Alternatives - If you are interested in alternative therapies such as acupuncture or massage therapy, Aetna has a program to meet your needs. Aetna's Natural Alternatives program offers you special rates on alternative therapies, including visits to acupuncturists, chiropractors, massage therapists and nutritional counselors.

Vitamin Advantage™ - You can save on vitamins and nutritional supplements purchased through mail order, over the phone, by fax, or through the Internet.

Natural Products - You also can save on many health-related products, including aromatherapy, foot care and natural body care products.

You may place orders by mail, telephone, fax or Internet to receive savings on health-related products offered through these programs.

To Find Out More - Call the Member Services number on your ID card, or visit Aetna on the web at <http://www.aetna.com>. There you can find a listing of participating providers, vendors and the latest additions to the product list. Visit the website often — these programs are growing!

Fitness Program

Aetna offers Plan participants access to the following discounted fitness services provided by GlobalFit™.

- Low or discounted membership rates at independent health clubs contracted with GlobalFit;
- Free guest passes to allow you to sample facilities before selecting a club* to join;
- Guest privileges at other participating GlobalFit health clubs, * and
- Discounts on certain home exercise equipment.

* *Not available at all clubs.*

To determine which program is offered in your area and to view a list of included clubs, visit the GlobalFit website at www.globalfit.com/fitness. If you would like to speak with a GlobalFit representative, you can call the GlobalFit Health Club Help Line at 1-800-298-7800.

Aetna Health Connections -- Disease Management

Aetna has thirty programs aimed at helping members and their physicians to better manage chronic disease. Aetna Health Connections will provide innovative and individualized clinical programs, information and support for *total* health management to help members achieve their optimal state of health.

With Aetna Health Connections, Aetna will be able to view members holistically – considering *multiple* diseases or conditions across *all* benefit plans – and deliver individualized programs based on their unique needs and preferences.

Additional information about Aetna's Disease Management Programs can be found on Aetna's website at <http://www.aetna.com>.

Simple Steps to a Healthier Life

The key to a long, healthy life is developing good health habits and sticking with them. Through the use of educational materials, Aetna's innovative Simple Steps Program offers health education, preventive care and wellness programs to Plan participants. These programs provide materials that, in conjunction with care and advice from a physician, help promote a healthy lifestyle and good health.

To obtain information on the Simple Steps Programs, call the toll-free number on your ID card or visit [http:// www.aetn navigator.com](http://www.aetn navigator.com).

Childhood Immunization Program

Children need immunizations to protect them from a number of dangerous childhood diseases that could have very serious complications. Vaccines have been proven to be powerful tools for preventing certain diseases. It has been shown over time that the risks of serious illness from not vaccinating children far outweigh any risk of reaction to immunization. The common childhood diseases that vaccinations can guard against are:

- Measles
- Mumps
- Rubella
- Polio
- Pertussis (whooping cough)
- Diphtheria
- Tetanus
- Haemophilus influenza type B
- Hepatitis B
- Varicella (chicken pox)

To promote good health through prevention, the Childhood Immunization Program sends immunization reminders to parents of children covered under this Plan.

An 18-month reminder is sent to families encouraging parents to schedule immunization visits with their pediatrician or family doctor if their child is not already fully immunized. This reminder contains a list of immunizations recommended at 18 months. * The objective of this reminder is to help promote timely childhood immunizations and to stress the importance of completing immunizations.

If you have questions about specific vaccinations, please call your pediatrician or your family doctor.

* *Source: Office of Prevention and Health Promotion, in cooperation with the agencies of Public Health Services, U.S. Department of Health and Human Services. Center for Disease Control and Prevention (CDC), American Association of Pediatrics (AAP), and Advisory Committee on Immunization Practices.*

Informed Health[®] Line 1-800-556-1555

Informed Health[®] Line provides eligible Plan participants with telephone access to registered nurses experienced in providing information on a variety of health topics. The nurses encourage informed health care decision making and optimal patient/provider relationships through information and support. However, the nurses do not diagnose, prescribe or give medical advice.

Informed Health Line is available to eligible employees and their families virtually 24 hours per day, 365 days per year from anywhere in the nation.

Backed by the Healthwise[®] Knowledgebase[™] (a computerized database of over 1,900 of the most common health problems) and an array of other online and desk references, the nurses help you understand health issues, treatment options, review specific questions to ask your provider, provide research analyses of treatments and diagnostic procedures, and explain the risks and benefits of various options. The nurses encourage patient/provider interaction by coaching you to give a clear medical history and information to providers and to ask clarifying questions.

National Medical Excellence Program[®]

Aetna's National Medical Excellence Program[®] helps eligible Plan participants access covered treatment for solid organ transplants, bone marrow transplants, and certain other rare or complicated conditions at participating facilities experienced in performing these services.

The program has three components:

- National Transplantation Program, designed to help arrange care for solid organ and bone marrow transplants.
- National Special Case Program, developed to coordinate arrangements for treatment of Plan participants with complex conditions at tertiary care facilities across the country when that care is not available within 100 miles of the Plan participant's home.
- Out of Country Program, designed for Plan participants who need emergency inpatient medical care while temporarily traveling outside the United States.

If you need a transplant or other specialized care that cannot be provided within the service area, the NME Program will coordinate covered services and will provide the following lodging and travel expenses if you must travel more than 100 miles:

- Transportation expenses you and a companion (if applicable) incur while traveling between your home and the Program facility. Travel expenses incurred by more than one companion are not covered;
- As the NME patient, your lodging expenses incurred while traveling between your home and the National Medical Excellence facility to receive covered services;
- The lodging expenses you incur for lodging away from home to receive covered outpatient services from a NME Program provider;
- The lodging expenses incurred by a companion traveling with you from your home to a National Medical Excellence provider so you can receive covered services; and
- Your companion's lodging expenses when their presence is required to enable you to receive services from a NME Program provider on either an inpatient or outpatient basis. Only the lodging expenses incurred by one companion are covered per night.

Benefits for travel and lodging expenses are subject to a maximum of \$10,000 per episode of care. Lodging expenses are subject to a \$50 per night maximum for each person.

Travel and lodging expenses must be approved in advance by Aetna; if you do not receive approval, the expenses are not covered.

You become eligible for coverage of travel and lodging expenses on the day you become a participant in the National Medical Excellence Program. Coverage ends on the earliest to occur of:

- One year after the day a covered procedure was performed;
- The date you cease to receive any services from the Program provider in connection with the covered procedure; or
- The date your coverage terminates under the Plan.

Travel and lodging expenses do not include expenses that are covered under any other part of the Plan.

The Plan covers only those services, supplies and treatments that are considered necessary for your medical condition. Treatment that is considered experimental (as determined by Aetna) is not covered by the Plan. Refer to the *Glossary* for a definition of “experimental.”

Aetna Vision Discount Program

Plan participants are eligible to receive discounts on eyeglasses, contact lenses and nonprescription items such as sunglasses and contact lens solutions through the Vision One program at thousands of locations nationwide. Just call 1-800-793-8616 for information and the location nearest you.

Plan participants are also eligible to receive a discount off the provider’s usual retail charge for Lasik surgery (the laser vision corrective procedure) offered by the U.S. Laser Network. Included in the discounted price is patient education, an initial screening, the Lasik procedure and follow-up care. To find the closest surgeons, call 1-800-422-6600 and speak to a Lasik customer service representative.

Women’s Health Care

Aetna is focused on the unique health care needs of women. They have designed a variety of benefits and programs to promote good health throughout each distinct life stage, and are committed to educating female Plan participants about the lifelong benefits of preventive health care.

Breast Cancer Case Management

Aetna's breast cancer case management program assists female Plan participants who have been diagnosed with breast cancer in making informed choices for their care. This special educational and support program includes:

- A dedicated breast cancer nurse case manager to answer your questions about coverage, assist with necessary claims authorizations, and facilitate access to treatment by participating specialists and primary care physicians and at participating facilities.
- Educational materials.

- Second opinions.

Case Management and Education for Diabetics Considering Pregnancy

Aetna provides diabetic women considering pregnancy with educational materials and nurse case management to help better manage their blood sugar levels prior to pregnancy, which can decrease the chance of delivering babies with birth defects.

Confidential Genetic Testing for Breast and Ovarian Cancers

Aetna covers confidential genetic testing for Plan participants who have never had breast or ovarian cancer, but have a strong familial history of the disease. Screening test results are reported directly to the provider who ordered the test. Other genetic tests are covered, which you can find in the clinical policy bulletins.

Note: Genetic testing of Aetna members is excluded from coverage under Aetna's benefit plans if the testing is performed primarily for the medical management of other family members who are not covered under an Aetna benefit plan. In these circumstances, the insurance carrier for the family members who are not covered by Aetna should be contacted regarding coverage of genetic testing. Occasionally, genetic testing of tissue samples from other family members who are not covered by Aetna may be required to provide the medical information necessary for the proper medical care of an Aetna member. Aetna covers genetic testing for heritable disorders in non-Aetna members when *all* of the following conditions are met:

1. The information is needed to adequately assess risk in the Aetna member; *and*
2. The information will be used in the immediate care plan of the Aetna member; *and*
3. The non-Aetna member's benefit plan, if any, will *not* cover the test (a copy of the denial letter* from the non-Aetna member's benefit plan must be provided).

*Aetna may also request a copy of the certificate of coverage from the non-member's health insurance plan if: 1) the denial letter from the non-member's insurance carrier fails to specify the basis for non-coverage; 2) the denial is based on a specific plan exclusion; or 3) the genetic test is denied by the non-member's insurance carrier as not medically necessary and the medical information provided to Aetna does not make clear why testing would not be of significant medical benefit to the non-member.

Beginning Right Maternity Management Program™

The Moms-to-Babies™ maternity management program provides you with maternity health care information, and guides you through pregnancy. This program provides:

- Educational materials on prenatal care, labor and delivery.
- Pregnancy Risk Survey – to identify potential risks or complications.
- Access to Obstetrical Nurses – who provide case management, education and post partum depression screening of high-risk members.
- Smoke-free Moms-to-be™, a personalized stop-smoking program designed specifically for pregnant women.
- Focused, educational information, “For Dad or Partner.”
- Access to Breastfeeding consultants.

Under the program, all care during your pregnancy is coordinated by your participating obstetrical care provider and Moms-to-Babies case managers, so there is no need to return to your PCP for referrals. However, your obstetrician will need to request a referral from Aetna for any tests performed outside of the office. To ensure that you are covered, please make sure your obstetrician has obtained this referral before the tests are performed.

Another important feature, ***Pregnancy Risk Assessment***, identifies women who may need more specialized prenatal and/or postnatal care due to medical history or present health status. If risk is identified, the program assists you and your physician in coordinating any specialty care that may be medically necessary.

Eligibility

Who Is Eligible to Join the Plan

You are eligible to enroll in the Plan if you meet the City of Scottsdale's eligibility requirements. Eligibility requirements are the following:

- regular, full time, job share and part time benefited employees of the City of Scottsdale working at least 20 hours per week and members of the City Council.
- retired employees and retired members of the City Council who are under age 65 and who draw monthly benefits under the Arizona State Retirement System, the Public Safety Retirement System or the Elected Officials Retirement System within 90 days of leaving employment with the City of Scottsdale and are not eligible for Medicare/Medicaid benefits. An election to join the plan must be made within 30 days of the day monthly pension benefits begin and within 90 days of leaving employment with the City of Scottsdale.

When you join the Plan, your spouse and your dependent children are also eligible to join.

Coverage for Dependent Children

To be eligible for coverage, a dependent child must be under 26 years of age. Any child can remain covered until age 26, even if the child is living away from home or is married, is not a student or the child is working. If the child is working or is married and has access to other health care coverage, they ARE NOT eligible to continue on the plan.

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody.

You may also cover your “domestic partner” or “domestic partner children” as dependents, in accordance with the rules established by the City of Scottsdale. A domestic partner is an individual of either sex who shares a long-term committed relationship of indefinite duration with a benefit eligible employee or retiree. A Domestic Partnership Affidavit must be completed and submitted with at least three items of

documentation as evidence of joint responsibility and commitment and that documentation must be predated by twelve months.

No person may be covered as both an employee and a dependent under the Plan, and no person may be covered as a dependent of more than one employee.

If Your Child Is Adopted

Coverage for your legally adopted child is effective on the date the child is adopted or placed with you for adoption if you request coverage for the child in writing within 31 days of the placement.

Individuals Residing Outside of the Local Service Area

If you or a dependent resides outside of the local Aetna service area, but live in another Aetna service area, you can use participating providers in that service area. Examples of this would be a retiree who has moved to a new location or a child who does not live with you. Contact Aetna at the telephone number listed on your identification card for more information on Aetna network locations.

A child covered by the Plan who does not reside in an Aetna service area can use participating providers in your network and return to your network service area for care.

In the event of an emergency that occurs outside of your service area, out-of-area dependents should obtain necessary care as described under “In Case of Emergency,” then contact their participating physician to coordinate follow-up care.

Incapacitated/Handicapped Dependents

Eligibility

Coverage for certain unmarried dependents beyond age 26 may be continued if the dependent:

- is incapable of self-support due to mental retardation or any other mental or physical handicap;
- is handicapped prior to attainment of the limiting age and is chiefly dependent on the employee for support on that date.
- is not covered under a medical expense conversion policy, and;
- remains dependent upon the insured parent or guardian for support and maintenance.

Members must make a request to Aetna, with both of the following forms completed – the Request for Continuation of Medical Coverage for Handicapped Child and the Handicapped Child Attending Physician’s statement. The forms should be received by Aetna within 90 days from the date the member reached the maximum age of coverage or within 90 days of the pended/denied claim or letter;

If the dependent is determined by Aetna to be permanently disabled, the system will be updated with the date the dependent became disabled and no further updates will be needed. If the dependent is determined by Aetna to be temporarily disabled and the case needs to be reviewed again, members will be required to provide further information to Aetna on a periodic basis.

Michelle's Law

Michelle's law (federal HR 2851) extends coverage to a dependent who suffers from a serious illness or injury which results in the dependent taking a medically necessary leave of absence from a post secondary institution.

Michelle's law applies to a dependent child who was enrolled in the Plan on the basis of being a student immediately before the first day of the medically necessary leave of absence. Coverage will continue until the earlier of:

- one year after the first day of the medically necessary leave; or
- the date on which coverage would otherwise terminate under the Plan.

The period of coverage runs from the date of disability/illness as certified by the physician regardless of when the disability/illness occurs.

Certification by physician

Certification that the dependent child is suffering from a serious illness or injury and that the leave of absence is medically necessary must be supported by a clinical certification of need from a physician licensed to practice medicine in all its branches.

Continued coverage when coverage changes

If the child is already on a medically necessary leave and the group plan changes the new plan will take over the coverage, and the dependent will be credited for the day/months the child has already been on the leave. Changing plans or carriers will not restart the continuation period.

Aetna will require written documentation from the health care provider indicating that the student is unable to attend school and a leave of absence is necessary. We must receive the enrollment form and the physician statement within 90 days from the start date of the medically necessary leave of absence from school.

Qualified Medical Child Support Order (QMCSO)

A QMCSO is a court order requiring a parent to provide health care benefits to one or more children. Coverage under the Plan can be extended to a child who is covered by a QMCSO, if:

- The QMCSO is issued on or after the date your coverage becomes effective; and
- Your child meets the age and student status requirements of an eligible dependent under the Plan; and
- You request coverage for the child within 31 days of the court order.

Coverage will be effective on the date of the court order. Contact your HR Division at x27600 for more information on QMCSOs.

Enrollment

New Employees

When you are first eligible to enroll in the Plan, you will be given enrollment and benefit information, including an enrollment form. You must request enrollment within 31 days of the date you become eligible.

You must complete the enrollment form and return it to your Human Resources representative in order for claims to be considered for payment under the plan. If you do not request enrollment within the 31-day period, your employer will assume that you have waived coverage, and you will not be allowed to participate in the Plan until the next open enrollment period, unless “a special enrollment situation” occurs.

An eligible employee may elect to waive coverage under the Plan. To do so you must submit to the HR division the completed written portion of the enrollment form that pertains to waiving coverage. Full time employees must provide proof of other coverage in order to waive medical coverage. Remember that a dependent may not be enrolled for coverage unless the employee is also enrolled. If at a later date you want the coverage you declined for yourself, you may enroll only under the Special Enrollment provisions (when applicable) or the Open Enrollment provisions described later in this chapter.

Open Enrollment

The annual open enrollment period is your opportunity to review your benefit needs for the upcoming year and to change your benefit elections, if necessary and for employees to enroll in the Plan if coverage was previously waived. Open enrollment will be held each spring, and the elections you make will be in effect for the plan year of July 1 through June 30.

Special Enrollment Due to Loss of Other Health Coverage

Under certain circumstances, an Eligible Employee or his/her Dependent who did not enroll during the initial enrollment period may enroll before the next open enrollment period. These circumstances warrant “special enrollment.” under HIPAA. Special enrollment shall be allowed for either of the following:

- The Eligible Employee or the Dependent satisfies all of the following criteria:
 - Was covered under a group health plan or health insurance coverage (this prior coverage does not include continuation coverage required under federal law) at the time the Eligible Employee or Dependent was first eligible to enroll under the Plan;
 - Declined coverage in writing for that reason;
 - Presents to the Employer evidence of a loss of the prior coverage due to a loss of eligibility for that coverage, or evidence of the termination of employer contributions toward that coverage (“loss of eligibility” includes loss of eligibility as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment; but it does not include a loss due to the failure of the Eligible Employee or Dependent to pay premiums on a timely basis or termination of the prior coverage for cause); and
 - Notifies the Employer in writing within thirty days of the date of the loss of coverage or the date the employer’s contribution toward that coverage terminates.
- The Eligible Employee or Dependent satisfies all of the following criteria:
 - Was covered under benefits available under COBRA;
 - Declined coverage for that reason;
 - Presents to the Employer evidence that the Eligible Employee has exhausted such COBRA coverage and has not lost such coverage due to the failure of the Eligible Employee or Dependent to pay premiums on a timely basis or termination of coverage for cause; and

- Notifies the Employer in writing within thirty days of the date of the loss of coverage.

Special Enrollment Due to Addition of Dependent

An Eligible Employee's marriage or the birth, adoption, placement for adoption, or legal guardianship of an Eligible Employee's child also triggers special enrollment rights under HIPAA.

- **Non-Participating Employees May Also Enroll.** The addition of a new Dependent triggers enrollment rights for an Eligible Employee even if he/she does not participate in the Plan at the time of the event. For example, upon the birth of an Eligible Employee's child, the Eligible Employee (assuming that he/she did not previously enroll), his/her Spouse, and his or her newborn child may all enroll because of the child's birth. The same rule applies to the Eligible Employee's marriage or adoption of a child if the Eligible Employee had not previously enrolled in the Plan.
- **Deadline for Special Enrollment Period.** The Eligible Employee must request special enrollment in the Plan within thirty days of marriage, satisfying the one year requirement for domestic partnership; or birth, adoption or placement for adoption of his/her child. If the Employer, or its designee, does not receive the eligible Employee's completed request for enrollment within this deadline, the Eligible Employee and his/her dependents lose special enrollment rights for that event.

CHIP Special Enrollment Notice

Effective April 1, 2009, the City of Scottsdale will also allow a special enrollment opportunity if you or your eligible dependents either:

- 1) lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- 2) become eligible for a state's premium assistance program under Medicaid or CHIP.

For these two new special enrollment opportunities, you have 60 days (instead of 30) from the date of the Medicaid/CHIP eligibility change to request enrollment in the City's group health plan.

Change in Status

Federal regulations generally require that your plan coverage remain in effect throughout the plan year. However, some changes may be allowed during the plan year if the Plan administrator determines that the individual has a qualifying change in status affecting their benefit needs. The change in coverage must be consistent with the change in status. As a result of a qualified status change, you may add or delete dependents from your coverage but you may not change plans. A qualified change in status is:

- Your marriage, divorce, legal separation or annulment; satisfying the one-year requirement for domestic partnership, or termination of the domestic partnership.
- The birth or adoption of a child;
- The death of your spouse or child;
- A change in the number of your dependents;
- A change in employment status for you, your spouse or your dependent; or
- The beginning or end of an unpaid leave of absence taken by you or your spouse.

Whenever you have a qualified change in status, you must report the change by completing a change form, available from your Human Resources representative. The completed change form must be given to your Human Resources representative within 30 days of the event. Otherwise, you must wait until your employer's next open enrollment period.

Effective Date of Coverage

The date on which coverage becomes effective depends upon when enrollment occurs.

- **Enrollment Within Initial Enrollment Period.** The effective date of coverage for employees who enroll during the initial enrollment period is the first day of the eligible employee's first day of employment or change to eligible status with the Employer. The effective date of coverage for Dependents is at the time of the Eligible Employee's enrollment.

If Dependent status is acquired after the Employee's initial eligibility, the effective date of coverage shall be the date on which the new Dependent becomes eligible for coverage under the Plan, provided the Employee completes a change form and submits it to the Employer within thirty days after the attainment of Dependent status.

- **Enrollment Not Within Initial Enrollment Period.** If an Eligible Employee or Dependent does not enroll within the initial enrollment period, he or she must wait until the next open enrollment period unless a "special enrollment" or "change in status" situation occurs. The effective date of coverage would be the first day of the Coverage Year for which the open enrollment period was held.
- **Special Enrollment.** When enrollment occurs as the result of a special enrollment due to loss of other health coverage as described above, the effective date of coverage is the first day of the month following the receipt and acceptance of the completed enrollment materials by the Employer or its designee. When enrollment occurs as the result of a special enrollment due to addition or adoption of a child as described above, the effective date of coverage is the date of the event.
- **Change in Life Status.** When enrollment occurs as the result of a qualified change in life status, the effective date of the coverage is the date of the life event.

Note: Newborn children are automatically covered for 31 days after birth. To continue the coverage beyond 31 days, you must apply by submitting a change form to your Human Resources representative within the 31-day period.

The Plan does not have any pre-existing condition limitation provisions.

When Coverage Ends

Termination of Employee Coverage

Your coverage will end on the last day in which the earliest of the following events occur:

- You voluntarily terminate coverage;
- Your employment terminates;
- You are no longer eligible for coverage;

- You do not make the required contributions;
- You become covered under another health care plan offered by your employer; or
- The Plan is discontinued.

Termination of Dependent Coverage

Coverage for your dependents will end on the last day in which the earliest of the following events occur:

- Your coverage ends for any of the reasons listed above or below;
- You die;
- Your dependent is no longer eligible for coverage;
- Your payment for dependent coverage is not made when due; or
- Dependent coverage is no longer available under the Plan.

Termination of Retiree Coverage

Coverage for retirees will end on the first day of the month in which the earlier of the following events occur. Re-enrollments at a later date are not permitted.

- The retiree reaches age 65.
- The retiree dies.
- The retiree opts out of such coverage.
- The retiree fails to pay necessary premiums to the employer within the established payment schedule as communicated directly to the retiree.

Termination for Cause

A Plan participant's coverage may be terminated for cause. "For cause" is defined as:

- **Untenable relationship:** After reasonable efforts, Aetna and/or the Plan's participating providers are unable to establish and maintain a satisfactory provider-patient relationship with you or a Plan participant of your family. You will be given 31 days advance written notice of the termination of coverage.
- **Failure to make copayments:** You or a member of your family fails to make any required copayment or any other payment that you are obligated to pay. You will be given 31 days advance written notice of the termination of coverage.
- **Refusal to provide COB information:** You or a member of your family refuses to cooperate and provide any facts necessary for Aetna to administer the Plan's COB provision. You will be given 31 days advance written notice of the termination of coverage.
- **Furnishing incorrect or incomplete information:** You or a member of your family willfully furnishes incorrect or incomplete information in a statement made for the purpose of enrolling in, or obtaining benefits from the Plan. Termination will be effective immediately.
- **Fraud against the Plan:** This may include, but is not limited to, allowing a person who is not a participant of the Plan to use your Aetna ID card. Termination will be effective immediately.
- **Misconduct:** You or a covered member of your family abuses the system, including (but not limited to) theft, damage to the property of a participating provider, or forgery of drug prescriptions. Termination will be effective immediately.

No benefits will be provided to you and your family members once coverage is terminated.

Any termination for cause is subject to review in accordance with the Plan's grievance process. You may request that Aetna conduct a grievance hearing within 15 working days after receiving notice that coverage has been or will be terminated. Coverage will be continued until a final decision on the grievance is rendered, provided you continue to make required contributions. Termination may be retroactive to the original date of termination if the final decision is in favor of Aetna.

Family and Medical Leave

If your employer grants you an approved family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), you may continue coverage for yourself and your eligible dependents during your approved leave. You must agree to make any required contributions.

The continued coverage will cease when:

- You fail to make any required contribution;
- Your approved leave is determined by your employer to be terminated; or
- The Plan is discontinued.

In addition, any coverage for a dependent will not be continued beyond the date it would otherwise terminate.

If you do not return to work at the end of the approved leave, your employer may recover from you the cost of maintaining your benefits coverage during the entire period of the leave, unless the failure to return to work was for reasons beyond your control.

If coverage under the Plan terminates because your approved FMLA leave is deemed terminated, you may, on the date of termination, be eligible to continue coverage under COBRA on the same terms as though your employment terminated on that date. If, however, your employment is terminated because of your gross misconduct, you will not be eligible for COBRA continued coverage. Contact your HR Division at x27600 for more information on FMLA.

Leave for Military Service/Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you go into active military service for up to 31 days, you can continue your health care coverage under this Plan during that leave period if you continue to pay your contributions for that coverage during the period of that leave. If you go into active military service for more than 31 days, you should receive military health care coverage at no cost; however, you may also continue this group health plan coverage under the provisions of USERRA, at your own expense, as follows:

- If you elect USERRA continuation coverage, the maximum period for this coverage is up to 24 months.

When your coverage under this Plan terminates because of your reduction in hours due to your military service, you and your eligible dependents may also have COBRA rights. See also the COBRA chapter of this document. Any coverage, which was terminated, will be reinstated immediately upon return to active

employment. Questions regarding your entitlement to this leave and to the continuation of health care coverage should be referred to the HR Division.

COBRA CONTINUATION OF COVERAGE

You and your dependents have the right under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to continue medical coverage under certain circumstances (called “qualifying events”) when you would otherwise lose coverage. To do so, you must elect coverage within the required time period and pay the required premium (will vary from 35% up to 102% of the full regular cost of coverage depending on the reason for termination).

Continuation of Coverage Following Termination of Employment or Loss of Eligibility

You and your eligible dependents (but not domestic partners) are eligible to continue coverage for up to 18 months if:

- You leave your employer for any reason other than gross misconduct and you had health care coverage through your employer at the time you left employment; or
- You are no longer eligible because your working hours are reduced and you had health care coverage through your employer at the time your hours are reduced.

You may elect to continue coverage for yourself and your dependents, or your dependents may each elect to continue their own coverage.

The American Recovery and Reinvestment Act of 2009 (ARRA) creates a temporary 65% premium subsidy for COBRA coverage for involuntarily terminated employees and their family members who meet certain requirements. The COBRA subsidy will apply for nine months. To qualify for the subsidy as an Assisted Eligible Individual (AEI), the employee must:

1. become eligible to elect COBRA because of an involuntary employment termination,
2. not be eligible for any other group health coverage, and
3. be terminated and lose coverage between September 1, 2008 and December 31, 2009

If you or your dependent is disabled, as defined by the Social Security Administration, at the time of the qualifying event or becomes disabled within 60 days of the event, you may be entitled to an extra 11 months of coverage, for a total of 29 months. You must notify your Human Resources representative of the disability before the end of the original 18-month period to receive the extension, and you must pay up to 150% of the full cost of coverage for every month after the 18th month. Coverage may be continued for the disabled individual and for any family member for whom coverage is already being continued under COBRA, as well as for your newborn or newly adopted child who was added after the date COBRA continuation began. COBRA continuation of benefits will end on the first day of the month that begins more than 30 days after the final determination under Title II or XVI of the Social Security Act that the disabled individual is no longer disabled.

Continuation of Coverage Due to Other Qualifying Events

Your eligible dependents can continue coverage for up to 36 months if coverage would otherwise cease because:

- You die;
- You are divorced;
- You stop making contributions for a spouse from whom you are legally separated;
- You become entitled to Medicare;
- A covered child is no longer eligible under the Plan.

If one of the above events occurs while you or a covered dependent have already continued coverage due to the termination of your employment or your loss of eligibility, your dependent may extend coverage beyond the original 18-month continuation period, but for no more than a total of 36 months from the date coverage would originally have ended.

Applying for COBRA Continuation

Your Human Resources representative will give you information about how to continue COBRA coverage at the time you become eligible.

You must inform your employer of any status changes that would make your dependents eligible for COBRA coverage within 60 days of the later to occur of:

- The occurrence of the event; and
- The date coverage would terminate due to the event.

To ensure that there is no break in coverage, the election to continue coverage under COBRA must be made within 60 days of:

- The date coverage would terminate due to the event; or
- The date your employer informs your dependents of their right to continue coverage; whichever happens later.

If you do not make an election within 60 days, you will lose your COBRA continuation rights.

Special Enrollment Rights

You have special enrollment rights under federal law that allows you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying events listed in this chapter. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

Procedure for Notifying the Plan of a Qualifying Event (Very Important Information)

In order to have the chance to elect COBRA Continuation Coverage after a divorce, legal separation, or a child ceasing to be a "dependent child" under the Plan, **you and/or a family member must inform the Plan in writing of that event no later than 60 days after that event occurs.**

That written notice should be sent to the Plan Administrator whose address is listed in this document. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, address, the

qualifying event, the date of the event, and appropriate documentation in support of the qualifying event, such as divorce documents.

Grace Periods

The initial payment for the COBRA Continuation Coverage is due to the Plan Administrator 45 days after COBRA Continuation Coverage is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect. After the initial COBRA payment, subsequent payments are due on the first day of each month, but there will be a 30-day grace period to make those payments. If payments are not made within the time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

Confirmation of Coverage Before Election or Payment of the Cost of COBRA Continuation Coverage

If a Health Care Provider requests confirmation of coverage and you, your Spouse or Dependent Child (ren) have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect or you, your Spouse or Dependent Child (ren) are within the COBRA election period but have not yet elected COBRA, COBRA Continuation Coverage will be confirmed, but with notice to the Health Care Provider that the cost of the COBRA Continuation Coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the COBRA Continuation Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

Addition of Newly Acquired Dependents

If, while you (the employee or retiree) are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that spouse or child for coverage for the balance of the period of COBRA Continuation Coverage if you do so within 31 days after the marriage, birth, adoption, or placement for adoption. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage. Contact the Plan Administrator to add a dependent.

Loss of Other Group Health Plan Coverage

If, while you (the employee or retiree) are enrolled for COBRA Continuation Coverage your spouse or dependent loses coverage under another group health plan, you may enroll the spouse or dependent for coverage for the balance of the period of COBRA Continuation Coverage. The spouse or dependent must have been eligible but not enrolled in coverage under the terms of the pre-COBRA plan and, when enrollment was previously offered under that pre-COBRA healthcare plan and declined, the spouse or dependent must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the spouse or dependent within 31 days after the termination of the other coverage. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a qualifying event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent, by the Plan Administrator an explanation indicating

why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Notice of Early Termination of COBRA Continuation Coverage

The Plan will notify a qualified beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the qualifying event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the qualified beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practical after the Plan Administrator determines that COBRA coverage will terminate early.

When COBRA Continuation Coverage Ends

Continuation coverage will end on the earliest date that:

- The COBRA continuation period expires.
- You or your family members do not make the required contributions in a timely manner.
- You or your family members become covered under another group health plan, unless that plan contains a provision that restricts the payment of benefits for a pre-existing condition. Once the pre-existing condition clause of the new plan ceases to apply, your COBRA coverage will cease.
- The date, after the election of COBRA that you or your family members become enrolled in Medicare.
- Your employer terminates this health plan.
- The date the lifetime benefit maximum is exhausted on all benefits.
- During an extension of the maximum coverage period to 29 months due to the disability of the covered person, the disabled person is determined by the Social Security Administration to no longer be disabled

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, your employer will give you a certificate confirming your participation in the Plan when your health coverage terminates under the Plan and if elected, under COBRA. Aetna will assist your employer with the preparation and distribution of the certificates. Certificates can be obtained from your Human Resources representative.

When your COBRA coverage ends, the Plan Administrator will automatically provide you and/or your covered Dependents (free of charge) with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. If your coverage under this Plan ends, and you and/or your covered Dependents become eligible for coverage under another group health plan, or if you buy, for yourself and/or your covered Dependents, a health insurance policy, you may need this certificate (to prove that you did not have a break in coverage of 63 consecutive days or more) in order to reduce any exclusion for Pre-Existing Conditions that may apply to you and/or your covered Dependents in that new group health plan or health insurance policy. The certificate will indicate the period of time you and/or they were covered under this Plan, and certain additional information that is required by law.

The certificate will be sent to you (or to any of your covered Dependents) by first class mail shortly after your (or their) coverage under this Plan ends. This certificate will be in addition to any certificate provided to you after your pre-COBRA group health coverage terminated. In addition, a certificate will be provided to you and/or any covered Dependent upon receipt of a written request for such a certificate if that request is received by the Plan Administrator within two years of the later of the end of coverage under this Plan or COBRA.

HIPAA CERTIFICATION OF CREDITABLE COVERAGE WHEN COVERAGE ENDS

When your coverage ends, you and/or your covered dependents are entitled by law to and will automatically be provided (free of charge) with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. Such a certificate will be provided to you shortly after the Plan knows or has reason to know that coverage for you and/or your covered dependent(s) has ended. You can present this certificate to your new employer/health plan to offset a pre-existing condition limitation that may apply under that new plan or use this certificate when obtaining an individual health insurance policy to offset a similar limitation.

Procedure for Requesting and Receiving a Certificate of Creditable Coverage: A certificate will be provided upon receipt of a written request for such a certificate that is received by the Plan Administrator within two years after the date coverage ended under this Plan. The written request must be mailed or faxed to the Plan Administrator (in care of the HR Department) and should include the names of the individuals for whom a certificate is requested (including spouse and dependent children) and the address where the certificate should be mailed. A copy of the certificate will be mailed by the Plan to the address indicated. See the COBRA chapter for an explanation of when and how certificates of coverage will be provided after COBRA coverage ends.

Claims

Timely Filing

All claims should be reported promptly. The deadline for filing a claim for any benefits is 90 days after the date of the claim.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than two years after the deadline.

Coordination of Benefits

This section applies if you are covered under another plan besides this health plan and determines how the benefits under the plans will be coordinated. If you are covered by more than one health benefit plan, you should file all claims with each plan.

When coordinating benefits with Medicare for Retiree Members, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act. All Retiree plan members who are eligible for Medicare Part B, should enroll in Medicare Part B so the Member does not assume the Part B claims costs. If a retiree or dependent who is eligible for Medicare Part B does not enroll in Medicare Part B, the plan will only pay secondary benefits.

If you or a dependent are eligible for Medicare due to End Stage Renal Disease or a disability but do not enroll in Medicare Part B, the Plan will pay secondary to any payments that would have been made by Medicare, had you enrolled in Part B, as your primary insurer; Aetna will estimate Medicare payments and pay up to the allowable expense that would have been paid by Medicare had you enrolled in Medicare Part B.

Getting Started - Important Terms

When used in this provision, the following words and phrases have the meaning explained herein.

Allowable Expense means a health care service or expense, including, coinsurance and copayments and without reduction of any applicable deductible, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

1. If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense. This does not apply if one of the Plans provides coverage for a private room.
2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.
3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.
4. The amount a benefit is reduced or not reimbursed by the primary Plan because a covered person does not comply with the Plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.
5. If all Plans covering a person are high deductible Plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible Plan's deductible is not an allowable expense, except as to any health expense that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

If a person is covered by one Plan that computes its benefit payments on the basis of reasonable or recognized charges and another Plan that provides its benefits or services on the basis of negotiated charges, the primary plan's payment arrangements shall be the allowable expense for all the Plans. However, if the secondary plan has a negotiated fee or payment amount different from the primary plan and if the provider contract permits, that negotiated fee will be the allowable expense used by the secondary plan to determine benefits.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an allowable expense and a benefit paid.

Closed Panel Plan(s). A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent. A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan. Any Plan providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or nongroup, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service Plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee Plans, labor organization plans, employer organization Plans, or employee benefit organization Plans;
- Medical benefits coverage in a group, group-type, and individual automobile “no-fault” and traditional automobile “fault” type contracts;
- Medicare or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the Plan includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered separate plans. For example, Medical coverage will be coordinated with other Medical plans, and dental coverage will be coordinated with other dental plans.

This Plan is any part of the contract that provides benefits for health care expenses.

Primary Plan/Secondary Plan. The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan’s benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan’s benefits.

When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Which Plan Pays First

When two or more **plans** pay benefits, the rules for determining the order of payment are as follows:

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
- The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:
 1. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.
 2. Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one plan is:
 - A. The primary plan is the plan of the parent whose birthday is earlier in the year if:
 - i. The parents are married or living together whether or not married;
 - ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
 - B. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, the plan of the parent's spouse is the primary plan.
 - C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:
 - The plan of the custodial parent;
 - The plan of the spouse of the custodial parent;
 - The plan of the noncustodial parent; and then
 - The plan of the spouse of the noncustodial parent.

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

3. Active Employee or Retired or Laid off Employee. The plan that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the primary plan. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
5. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, subscriber longer is primary.
6. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, this plan will not pay more than it would have paid had it been primary.

Coordination of Benefits Process

In determining the amount to be paid when this plan is secondary on a claim, the secondary plan will calculate the benefits that it would have paid on the claim in the absence of other health insurance coverage and apply that amount to any allowable expense under this plan that was unpaid by the primary plan. The amount will be reduced so that when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense.

In addition, a secondary plan will credit to its plan deductible any amounts that would have been credited in the absence of other coverage.

Under the COB provision of this plan, the amount normally reimbursed for covered benefits or expenses under this plan is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under this plan for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. When the COB rules of this plan and another plan both agree that this plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

If a covered person is enrolled in two or more closed panel plans COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both plans.

Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this plan and other plans. Aetna has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility of Payment

Any payment made under another plan may include an amount, which should have been paid under this plan. If so, Aetna may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this plan. Aetna will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Aetna is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Subrogation and Right of Recovery Provision

Definitions

As used throughout this provision, the term Responsible Party means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person’s injury, illness or condition. The term Responsible Party includes the liability insurer of such party or any Insurance Coverage.

For purposes of this provision, the term Insurance Coverage refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile Insurance Coverage, or any first party Insurance Coverage.

For purposes of this provision, a Covered Person includes anyone on whose behalf the plan pays or provides any benefit including, but not limited to, the minor child or dependent of any plan member or person entitled to receive any benefits from the plan.

Subrogation

Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person’s injury, illness or condition to the full extent of benefits provided or to be provided by the plan.

Reimbursement

In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an injury, illness or condition, the plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts the plan has paid and will pay as a result of that injury, illness or condition, from such payment, up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that if he/she receives any payment from any Responsible Party as a result of an injury, illness or condition, he/she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person’s fiduciary duty to the plan.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition for which Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise, including from any Insurance Coverage, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, the Covered Person, the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the plan.

First-Priority Claim

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person acknowledges that the plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the plan before any other claim for the Covered Person's damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from *any and all* settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation

The Covered Person shall fully cooperate with the plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the Covered Person. The Covered Person and his/her agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights, or failure to reimburse the plan from any settlement or recovery obtained by the Covered Person, may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

The Covered Person shall do nothing to prejudice the plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of the plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

The Covered Person acknowledges that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify any Responsible Party. The plan reserves the right to notify Responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

Workers' Compensation

If benefits are paid under the Aetna medical benefits plan and Aetna determines you received Workers' Compensation benefits for the same incident, Aetna has the right to recover as described under the *Subrogation and Right of Reimbursement* provision. Aetna, on behalf of the Plan, will exercise its right to recover against you.

The Recovery Rights will be applied even though:

- The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that bodily injury or illness was sustained in the course of or resulted from your employment;
- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by you or the Workers' Compensation carrier; or
- The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by this Aetna medical benefits plan, you will notify Aetna of any Workers' Compensation claim you make, and that you agree to reimburse Aetna, on behalf of the Plan, as described above.

If benefits are paid under this Aetna medical benefits plan, and you or your covered dependent recover from a responsible party by settlement, judgment or otherwise, Aetna, on behalf of the Plan, has a right to recover from you or your covered dependent an amount equal to the amount the Plan paid.

Aetna Claim Procedures

A claim occurs whenever a Plan participant requests:

- An authorization or referral from a participating provider or Aetna; or
- Payment for items or services received.

Because you are a participant in a PPO plan, you do not need to submit a claim for most of your covered in-network healthcare expenses. However, you must submit your claims for out-of-network expenses. The claim must be submitted promptly to Aetna for payment. Send the itemized bill with a claim form for payment with your identification number clearly marked to the address shown on your ID card. Claim forms are available at www.scottsdaleAz.gov/jobs/Benefacts.

Aetna will make a decision on your claim. For concurrent care claims, Aetna will send you written notification of an affirmative benefit determination. For other types of claims, you may only receive written notice if Aetna makes an adverse benefit determination.

Adverse benefit determinations are decisions the Plan or its designees make that result in denial, reduction, or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service. Adverse benefit determinations can be made for one or more of the following reasons:

- The individual is not eligible to participate in the Plan; or
- Aetna determines that a benefit or service is not covered by the Plan because:
 - it is not included in the list of covered benefits,
 - it is specifically excluded,
 - a Plan limitation has been reached, or
 - it is not medically necessary.

Aetna will provide you with written notices of adverse benefit determinations within the time frames shown below. These time frames may be extended under certain limited circumstances. The notice you receive from Aetna will provide important information that will assist you in making an appeal of the adverse benefit determination, if you wish to do so. Please see “Grievances and Appeals” for more information about appeals.

Type of Claim	Response Time
Urgent care claim: a claim for medical care or treatment where delay could: <ul style="list-style-type: none">• Seriously jeopardize your life or health, or your ability to regain maximum function; or• Subject you to severe pain that cannot be adequately managed without the requested care or treatment.	As soon as possible but not later than 72 hours
Pre-service claim: a claim for a benefit that requires Aetna’s approval of the benefit in advance of obtaining medical care.	15 calendar days
Concurrent care claim extension: a request to extend a previously approved course of treatment.	Urgent care claim - as soon as possible, but not later than 24 hours, provided the request was received at least 24 hours prior to the expiration of the approved treatment.

	Other claims - 15 calendar days
Concurrent care claim reduction or termination: a decision to reduce or terminate a course of treatment that was previously approved.	With enough advance notice to allow the Plan participant to appeal.
Post-service claim: a claim for a benefit that is not a pre-service claim.	30 calendar days

Extensions of Time Frames

The time periods described in the chart may be extended as described below.

For urgent care claims: If Aetna does not have sufficient information to decide the claim, you will be notified as soon as possible (but no more than 24 hours after Aetna receives the claim) that additional information is needed. You will then have at least 48 hours to provide the information. A decision on your claim will be made within 48 hours after the additional information is provided.

For non-urgent pre-service and post-service claims: The time frames may be extended for up to 15 additional days for reasons beyond the plan's control. In this case, Aetna will notify you of the extension before the original notification time period has ended. If you fail to provide the information, your claim will be denied.

If an extension is necessary because Aetna needs more information to process your post service claim, Aetna will notify you and give you an additional period of at least 45 days after receiving the notice to provide the information. Aetna will then inform you of the claim decision within 15 days after the additional period has ended (or within 15 days after Aetna receives the information, if earlier). If you fail to provide the information, your claim will be denied.

Aetna Grievances and Appeals

The Plan has procedures for you to follow if you are dissatisfied with a decision that the Plan or its designee have made or with the operation of the Plan. The process depends on the type of complaint you have. There are two categories of complaints:

- Quality of care or operational issues; and
- Adverse benefit determinations.

Complaints about quality of care or operational issues are called grievances. Complaints about adverse benefit determinations are called appeals.

Grievances

Quality of care or operational issues arise if you are dissatisfied with the service received from Aetna or want to complain about a participating provider. To make a complaint about a quality of care or operational issue (called a grievance), call or write to Member Services within 30 days of the incident. Include a detailed description of the matter and include copies of any records or documents that you think are relevant

to the matter. Aetna will review the information and provide you with a written decision within 30 calendar days of the receipt of the grievance, unless additional information is needed, but cannot be obtained within this time frame. The notice of the decision will specify what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations

Aetna will send you written notice of an adverse benefit determination. The notice will give the reason for the decision and will explain what steps you must take if you wish to appeal. The notice will also tell you about your rights to receive additional information that may be relevant to the appeal. Requests for appeal must be made in writing within 180 days from the receipt of the notice. However, appeals of adverse benefit determinations involving urgent care may be made orally.

The Plan provides for three levels of appeal. If you are dissatisfied with the outcome of your level one appeal and wish to file a level two appeal, your appeal must be filed no later than 60 days following receipt of the level one notice of adverse benefit determination. If you are dissatisfied with the outcome of your level two appeal and wish to file a level three appeal, your appeal must be filed no later than 30 days following receipt of the level one notice of adverse benefit determination. The following chart summarizes some information about how appeals are handled for different types of claims.

AETNA RESPONSE TIME TO MEMBER APPEALS

Type of Claim	Level One Appeal	Level Two Appeal
Urgent care claim: a claim for medical care or treatment where delay could: <ul style="list-style-type: none"> • Seriously jeopardize your life or health, or your ability to regain maximum function; or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment. 	36 hours Review provided by Aetna personnel not involved in making the adverse benefit determination.	36 hours Review provided by City of Scottsdale Benefits Coordinating Committee.
Pre-service claim: a claim for a benefit that requires Aetna's approval of the benefit in advance of obtaining medical care.	15 calendar days Review provided by Aetna personnel not involved in making the adverse benefit determination.	15 calendar days Review provided by City of Scottsdale Benefits Coordinating Committee.
Concurrent care claim extension: a request to extend a previously approved course of treatment.	15 calendar days Treated like an urgent care claim or a pre-service claim	15 calendar days Treated like an urgent care claim or a pre-service claim

	depending on the circumstances	depending on the circumstances
Post-service claim: a claim for a benefit that is not a pre-service claim.	30 calendar days Review provided by Aetna personnel not involved in making the adverse benefit determination.	30 calendar days Review provided by City of Scottsdale Benefits Coordinating Committee.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna. However, in case of an urgent care claim or a pre-service claim, a physician familiar with the case may represent you in the appeal.

For a level two appeal, the covered person must make his/her request to the City of Scottsdale Benefits Coordinating Committee in writing. The request must be filed within 60 days of the date of receipt of the level one notice of adverse determination. The request must provide additional information and contain a copy of the reviewed denial letter and be filed by mail or hand delivered to:

City of Scottsdale
Benefits Coordinating Committee
Human Resources
7575 E. Main Street
Scottsdale, AZ 85251

It is the duty of the covered person to provide copies of the denial letter, all supporting bills and medical provider letters relative to medical condition and treatment, stating why the claim should be paid.

The covered person does not need to attend the meeting of the City of Scottsdale Benefits Coordinating Committee. Should the covered person request to attend; they must notify the Benefits Coordinating Committee in writing indicating who would attend. Only the covered person and/or one representative may attend. The Benefits Coordinating Committee has the right to impose reasonable time limits on any presentation by the covered person or their representative.

Requests for appeal, which do not comply with this procedure and time limitation, will not be considered.

Level Three Appeal Process – External Independent Review

The Member may obtain External Independent Medical Review only after the Member has sought any Appeals through standard and expedited Level One and Level Two. The Member has 30 days after receipt of written notice from Aetna or the City of Scottsdale that the Member's Formal Appeal or Expedited Medical Review has been denied to request External Independent Medical Review. The Member must send a written request for External Independent Medical Review and any material justification or documentation to support the Member's request for the covered service or claim for a covered service to:

Name: Priscilla Bugari, R.N.
Title: Director, Aetna National External Review Unit
Address: 11675 Great Oaks Way, Alpharetta, GA 30022
Phone: 1-877-848-5855 (Toll-free number)
Fax: 1-770-346-1087

Neither the Member nor the Member's treating Provider is responsible for the cost of any External Independent Medical Review.

There are 2 types of External Independent Medical Review Appeals, depending on the issues in the Member's case:

1. Medical Necessity Appeals are cases where Aetna has decided not to authorize a service because Aetna believes the service(s) the Member or the Member's treating Provider are asking for, are not Medically Necessary to treat the Member's condition. The external independent reviewer is a Provider retained by an outside Independent Review Organization ("IRO"), that is procured by the Arizona Insurance Department, and not connected with Aetna. The IRO Provider must be one who typically manages the condition under review.

Within 5 business days of receiving the Member's or the Director of Insurance's request, or if Aetna initiates an External Independent Medical Review, Aetna must:

- Mail a written acknowledgement to the Director of Insurance, the Member, and the Member's treating Provider.
- Send the Director of Insurance: the request for review; the Member's Aetna Certificate of Coverage or Group Insurance Certificate; all medical records and supporting documentation used to render Aetna decision; a summary of the applicable issues including a statement of Aetna decision; the criteria used and clinical reasons for Aetna decision; and the relevant portions of Aetna utilization review guidelines. We must also include the name and credentials of the Provider who reviewed and upheld the denial at the earlier Appeal levels.

Within 5 business days of receiving Aetna information, the Director of Insurance must send all the submitted information to an expedited, external independent review organization (the "IRO").

Within 21 business days of receiving the information, the IRO must make a decision and send the decision to the Director of Insurance.

Within 5 business days of receiving the IRO's decision, the Director of Insurance will mail a notice of the decision to Aetna, the Member, and the Member's treating Provider.

2. Contract Coverage issues are Appeals where Aetna has denied coverage because Aetna believes the requested service is not covered under the Member's Aetna Certificate of Coverage or Group Insurance Certificate. For these Appeals, the Arizona Insurance Department is the external independent reviewer.

Within 5 business days of receiving the Member's request or if Aetna initiates an External Independent Medical Review, Aetna must:

- Mail a written acknowledgement of the Member's request to the Director of Insurance, the Member, and the Member's treating Provider.
- Send the Director of Insurance: the request for review, the Member's Aetna Certificate of Coverage or Group Insurance Certificate; all medical records and supporting documentation used

to render Aetna decision; a summary of the applicable issues including a statement of Aetna decision, the criteria used and any clinical reasons for our decision and the relevant portions of Aetna utilization review guidelines.

Within 15 business days of receiving this information, the Director of Insurance will determine if the service or claim is covered, issue a decision, and send a notice of determination to Aetna, the Member, and the Member's treating Provider.

The Director of Insurance is sometimes unable to determine issues of coverage. If this occurs or if the Director of Insurance finds that the case involves a medical issue, the Director of Insurance will forward the Member's case to an IRO. The IRO will have 21 business days to make a decision and send it to the Director of Insurance. The Director of Insurance will have 5 business days after receiving the IRO's decision to send the decision to Aetna, the Member, and the Member's treating Provider.

Unless there are special circumstances, the appeals process outlined above must be completed prior to initiating legal action regarding a claim. If a Claimant intends to initiate legal action, he or she must do so within two years after receipt of a notification of Adverse Benefit Determination at the second level of appeal. If, due to special circumstances the Claimant was not required to complete the appeals process outlined above, legal action must be brought within two years of the date the Claimant's claim for benefits was submitted to the Plan. Claimants may not bring legal action after the expiration of the two-year period.

Claim Fiduciary

Aetna handles and is Fiduciary for all Level 1 appeals, including External Review Organization (if applicable). The Plan Administrator is Fiduciary and handles Level 2 appeals.

Fiduciary Definition

A person is a fiduciary under an ERISA plan to the extent that he/she performs any of the following:

- a. Exercises any discretionary authority or control respecting management of the plan or disposition of its assets.
- b. Renders investment advice for a fee or other compensation, direct or indirect, with respect to any monies or other property of the plan, or has any authority or responsibility to do so.
- c. Has any discretionary authority or responsibility in the administration of the plan.

Your Plan Administrator has complete discretionary authority to review all denied claims for benefits under the Plan. This includes, but is not limited to, determining whether hospital or medical treatment is, or is not, medically necessary. In exercising its responsibilities, your employer has discretionary authority to:

- Determine whether, and to what extent, you and your covered dependents are entitled to benefits; and
- Construe any disputed or doubtful terms of the Plan.

Your employer has the right to adopt reasonable policies, procedures, rules and interpretations of the Plan to promote orderly and efficient administration. Your employer may not abuse its discretionary authority by acting arbitrarily and capriciously.

Your employer is responsible for making reports and disclosures required by applicable laws and regulations.

Member Services

Aetna Member Services Department

Customer service representatives (CSR's) are trained to answer your questions and to assist you in using the Plan properly and efficiently.

Call the toll-free number on your ID card to speak to a representative to:

- Ask questions about benefits and coverage;
- Notify Aetna about an emergency.
- Obtain information about Aetna special programs.
- Find a doctor in your area.

Please call your physician's office directly with questions about appointments, hours of service or medical matters.

InteliHealth®

InteliHealth is Aetna's online health information affiliate. It is one of the most complete consumer health information networks ever assembled. Through this unique program, Plan participants have access, via the Internet, to the wisdom and experience of some of the world's top medical professionals in the field today. Access InteliHealth through the Aetna Internet website home page or directly via **www.intelihealth.com**.

Aetna Navigator™

Aetna Navigator provides a single location for the health and medical issues that matter most to you.

In one easy-to-use website, you can perform a variety of self-service functions and take advantage of a vast amount of health information from InteliHealth®. Access Aetna Navigator™ through the Aetna Internet website home page or directly via **www.aetn navigator.com**.

When you visit the website, you can see some of Aetna Navigator's distinct features:

- A wealth of health information from InteliHealth, a premier provider of online consumer-based health, wellness and disease-specific information.
- Online customer service functions that allow you to order ID cards and send e-mail inquiries to Member Services.

- Interactive tools, including a pregnancy risk survey, breast health survey and estimate the cost of care and medications. To access these tools look under “Benefits” then “Health Programs”
- A preventive care planner that includes recommendations for screenings and immunizations.

Plan participants with certain Aetna plans may also create password-protected Web pages that are personalized to their health care interests. They have access to the features listed above as well as other options including:

- A personal “benefits snapshot” and claims summary.
- DocFind-A-Specialist, Aetna’s enhanced online provider directory that helps Plan participants select a specialist based on personal needs and preferences.
- An online survey that allows you to receive customized information based on your personal health interests.

Rights and Responsibilities

Your Rights and Responsibilities

As a Plan participant, you have a right to:

- Get up-to-date information about the doctors and hospitals participating in the Plan's network.
- Obtain primary and preventive care from the providers you chose.
- Obtain covered care from specialists, hospitals and other providers.
- Be told by your doctors how to make appointments and get health care during and after office hours.
- Be told how to get in touch with your physician or a back-up doctor 24 hours a day, every day.
- Call 911 (or any available area emergency response service) or go to the nearest emergency facility in a situation that might be life-threatening.
- Be treated with respect for your privacy and dignity.
- Have your medical records kept private, except when required by law or contract, or with your approval.
- Help your doctor make decisions about your health care.
- Discuss with your doctor your condition and all care alternatives, including potential risks and benefits, even if a care option is not covered.
- Know that your doctor cannot be penalized for filing a complaint or appeal.
- Know how the Plan decides what services are covered.
- Know how your doctors are compensated for the services they provide. If you would like more information about Aetna's physician compensation arrangements, visit their website at **www.aetna.com**. Select DocFind from the drop-down menu under Quick Tools, then under "How do I learn more about:" select the type of plan you're enrolled in.
- Get up-to-date information about the services covered by the Plan — for instance, what is and is not covered, and any applicable limitations or exclusions.
- Get information about copayments, coinsurance and fees you must pay.
- Be told how to file a complaint, grievance or appeal with the Plan.
- Receive a prompt reply when you ask the Plan questions or request information.
- Obtain your doctor's help in decisions about the need for services and in the grievance process.
- Suggest changes in the Plan's policies and services.

As a Plan participant, you have the responsibility to:

- Help your doctor make decisions about your health care.
- Tell your physician if you do not understand the treatment you receive and ask if you do not understand how to care for your illness.
- Follow the directions and advice you and your doctors have agreed upon.
- Tell your doctor promptly when you have unexpected problems or symptoms.
- Make sure you have the appropriate authorization for certain services, including inpatient hospitalization.
- Call your physician before getting care at an emergency facility, unless a delay would be detrimental to your health.
- Understand that participating doctors and other health care providers who care for you are not employees of Aetna and that Aetna does not control them.
- Show your ID card to providers before getting care from them.
- Pay the copayments, coinsurance and deductibles required by the Plan.
- Call Member Services if you do not understand how to use your benefits.
- Promptly follow the Plan's grievance procedures if you believe you need to submit a grievance.
- Give correct and complete information to doctors and other health care providers who care for you.
- Treat doctors and all providers, their staff, and the staff of the Plan with respect.
- Advise Aetna about other medical coverage you or your family members may have.
- Not be involved in dishonest activity directed to the Plan or any provider.
- Retirees and dependents of retirees should enroll in Medicare if eligible through a disability or end stage renal disease. All Retiree plan members who are eligible for Medicare Part B, should enroll in Medicare Part B so the member does not assume the Part B claims costs. If a plan member who is eligible for Medicare Part B does not enroll in Medicare Part B, the plan will only pay secondary benefits.
- Read and understand your Plan and benefits. Know the copayments, deductibles and coinsurance amounts and what services are covered and what services are not covered.

Federal Notices

The Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice About The Early Retiree Reinsurance Program

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

The Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

- (1) all stages of reconstruction of the breast on which a mastectomy has been performed;
- (2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
- (3) prostheses; and
- (4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, <http://www.cms.gov/HealthInsReformforConsume/>, and this U.S. Department of Labor website, http://www.dol.gov/ebsa/consumer_info_health.html

Plan Information

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

General Information About the Plan

Employer/Plan Sponsor	City of Scottsdale Human Resources 7575 E. Main Street Scottsdale, AZ 85251 (480) 312-7600
Employer Identification Number	86-6000735
Plan Name	City of Scottsdale Open Access High Level CPOSII Plan
Plan Year	The Plan Year runs from July 1-June 30
Plan Administrator	City of Scottsdale Human Resources 7575 E. Main Street Scottsdale, AZ 85251 (480) 312-7600
Type of Administration	The Plan is self-insured with the exception of behavioral health benefits and contracts with an independent claims administrator: Aetna

	Life Insurance Company. Behavioral health benefits are provided by CIGNA Behavioral Health on an insured basis.
Source of Contributions to the Plan	Employer and employee/retiree contributions
Agent for Service of Legal Process	City of Scottsdale

Amendment or Termination of the Plan

Your employer has the right to amend or terminate the Plan, in whole or in part, at any time. If a change is made, you will be notified.

The establishment of an employee benefit plan does not imply that employment is guaranteed for any period of time or that any employee receives any nonforfeitable right to continued participation in any benefits plan.

Plan Documents

This plan description provides complete plan information for the Open Access High Level CPOSII Plan administered by Aetna Life Insurance Company, effective July 1, 2009. The plan description has been designed to provide a clear and understandable description of the Plan and serves as the Summary Plan Description (SPD).

Glossary

A

Allowable Expense(s)

Any medically necessary health care service or expense, part or all of which is covered in full or in part under any of the plans covering the Plan participant for whom the claim is made. This means that an expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense.

Appeals

A process used by a Plan participant to request the health plan re-consider a previous authorization or claim decision.

Authorization: See Pre-Authorization/Pre-Certification

B

Benefit

Payment received for covered services under the terms of the Plan.

Benefit Period

The maximum length of time for which benefits will be paid.

Brand Name Drug

A prescription drug that is protected by trademark registration.

C

Case Management

A process of identifying individuals at high risk for problems associated with complex health care needs and assessing opportunities to coordinate care to optimize the outcome.

Certification: See Pre-Authorization/Pre-Certification

Chemotherapy

Treatment of malignant disease by chemical or biological antineoplastic agents.

Chiropractic Care

An alternative medicine therapy in which the spine and joints are adjusted to treat pain and improve general health.

Claim

A request for payment of benefits for health care services provided to a Plan participant.

Coinsurance

The sharing of certain covered expenses by the Plan and the Plan participant. For example, if the Plan covers an expense at 90% (the Plan's coinsurance), your coinsurance share is 10%.

Companion

A person whose presence as a companion or caregiver is necessary to enable a National Medical Excellence (NME) patient to:

- Receive services from an NME Program provider on an inpatient or outpatient basis; or
- Travel to and from an NME Program provider to receive covered services.

Contract

A legal agreement between the City of Scottsdale and Aetna Life Insurance Company that describes administrative responsibilities, benefits, and limitations of the coverage.

Coordination of Benefits (COB)

A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their benefits and provides the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

Copayment

The specified dollar amount or percentage required to be paid to a participating provider by, or on behalf of, a Plan participant in connection with benefits.

Covered Benefits or Covered Services

Those medically necessary services and supplies, which are covered in whole or in part under the Plan.

Custodial Care

Any type of care where the primary purpose of the type of care provided is to attend to the Plan participant's daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of this include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by the Plan participant, and general maintenance care of colostomy or ileostomy.

D

Deductible - means the amount of covered expenses that a Plan participant must pay each plan year before the Plan begins paying benefits. There are separate deductibles for in-network and out-of-network expenses.

Diagnostic Tests

Tests and procedures ordered by a provider to determine if a patient has a specific condition or disease based upon specific signs or symptoms demonstrated by the patient. Such diagnostic tools include, but are not limited to, radiology, ultrasound, nuclear medicine, and laboratory and pathology services or tests.

Direct Access

Under the Plan, the Plan participant may have “direct access” (sometimes referred to as “open access”) to any participating provider **of a specified specialty** without a referral.

DocFind®

Aetna’s electronic provider directory (updated weekly) on the Aetna website. You can research participating physicians, hospitals, dentists, pharmacists and other providers in your area through DocFind.

Durable Medical Equipment (DME)

Equipment that is:

- Made for and mainly used in the treatment of a disease or injury;
- Made to withstand prolonged use;
- Suited for use while not confined as an inpatient in the hospital;
- Not normally of use to persons who do not have a disease or injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Drug Formulary

A listing of prescription drugs and insulin established by Aetna that includes both brand name prescription drugs and generic prescription drugs. This list is subject to periodic review and modification by Aetna. Drugs listed on the formulary are covered under the prescription drug plan, with copayments as shown in the “Summary of Benefits.” Also called “formulary.”

E**Effective Date**

The date on which the coverage under a Plan participant’s plan goes into effect at 12:01a.m.

Emergency (also called medical emergency.)

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy,
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Experimental

A drug, device, procedure or treatment will be determined to be experimental by the Plan or its designee if:

- There is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- Required FDA approval has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or

- The written protocol or protocol (s) used by the treating facility or the protocol or protocol (s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
- It is not of proven benefit for the specific diagnosis or treatment of a Plan participant's particular condition; or
- It is not generally recognized by the medical community as effective or appropriate for the specific diagnosis or treatment of a Plan participant's particular condition; or
- It is provided or performed in special settings for research purposes.

Explanation of Benefits

An Explanation of Benefits form is provided to Plan participants to explain how the payment amount for a health benefit claim was calculated. Among other things, the Explanation of Benefits may explain the claims appeal process.

F

Formulary: See Drug Formulary

G

Generic Drug

A prescription drug that is not protected by trademark registration, but is produced and sold under the chemical formulation name.

H

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA is a federal law enacted in 1996. It was designated to improve availability and portability of health coverage by:

- Limiting exclusions for pre-existing conditions;
- Providing credit for prior health coverage;
- Allowing transmittal of the coverage information (i.e., covered family members and coverage period) to a new insurer;
- Providing new rights to allow individuals to enroll for health coverage when they lose their health coverage or have a new dependent;
- Prohibiting discrimination in enrollment/premiums
- Guaranteeing availability of health insurance coverage for small employers.

HIPAA's Administrative Simplification rules are designed to improve the efficiency of the health care system by standardizing the electronic exchange of health information and protecting the security and privacy of Plan participant-identifiable health information.

Home Health Care

Skilled nursing and other therapeutic services provided by a home health care agency in a home setting as an alternative to confinement in a hospital or skilled nursing facility.

Hospice Care

This is palliative and supportive care, either on an inpatient or outpatient basis, given to a terminally ill person and to his or her family. The focus of hospice programs is to enable terminally ill patients to remain, for as long as they can, in the familiar surroundings of their home.

Hospital

An institution rendering inpatient and outpatient services, accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by Aetna as meeting reasonable standards. A hospital may be a general, acute care, rehabilitation, or specialty institution.

I**ID Card**

Your ID card provides proof of your Plan coverage. An ID card is sent to you after your enrollment is processed and accepted. Your ID card includes your Plan participant identification number, as well as the toll-free phone number to contact Aetna Member Services. If you need to request a new ID card, you may do so through Member Services.

Infertility

For a female who is under age 35, the inability to conceive after one year or more without contraception or 12 cycles of artificial insemination.

For a female who is age 35 or older, the inability to conceive after six months without contraception or six cycles of artificial insemination.

Infusion Therapy

Treatment accomplished by placing therapeutic agents into the vein, including intravenous feeding. Such therapy also includes enteral nutrition, which is the delivery of nutrients into the gastrointestinal tract by tube.

In-Network

Refers to services received from participating providers.

Inpatient Care

Service provided after the patient is admitted to the hospital, skilled nursing facility or hospice. Inpatient care lasts 24 hours or more.

InteliHealth[®]

Intelihealth is Aetna's online health information site offered in association with the Harvard Medical School. It is a provider of online consumer-based health, wellness and disease specific information. You can link to Intelihealth from Aetna's website (www.aetna.com).

M

Medical Emergency: See Emergency.

Medically Necessary: See Necessary

Member Services

The Aetna Member Services department assists Plan participants with questions about plan benefits and exclusions and, if applicable to your plan. Calling the toll-free number on your ID card will connect you with your plan's Aetna Member Services office. If you do not have your ID card yet, contact Human Resources Benefits Office for the Member Services toll-free number.

Mental Disorder

A dysfunctional manifestation in the individual that may be physical, psychological or behavioral, and for which treatment is generally provided under the direction of a mental health professional such as a psychiatrist, a psychologist or a psychiatric social worker.

N

Necessary, Medically Necessary, Medically Necessary Services, or Medical Necessity

As determined by the Plan Administrator or its designee, means services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards, as described in the “Your Benefits” section of this booklet. To be medically necessary, the service or supply must:

- Be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition;
- Be a diagnostic procedure, indicated by the health status of the Plan participant, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition; and
- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

In determining whether a service or supply is medically necessary, the Plan or its designee will consider:

- Information provided on your health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- The opinion of health professionals in the generally recognized health specialty involved;
- The opinion of the attending physicians, which has credence but does not overrule contrary opinions; and
- Any other relevant information brought to the Plan or its designee’s attention.

In no event will the following services or supplies be considered medically necessary:

- Services or supplies that do not require the technical skills of a medical, mental health or dental professional;
- Services or supplies furnished mainly for the personal comfort or convenience of the patient, any person caring for the patient, any person who is part of the patient's family or any health care provider;
- Services or supplies furnished solely because the Plan participant is an inpatient on any day when their disease or injury could be diagnosed or treated safely and adequately on an outpatient basis; or
- Services furnished solely because of the setting if the service or supply could be furnished safely and adequately in a physician's or dentist's office or other less costly setting.

Network

Physicians, hospitals and other health care providers who contract with Aetna to participate in health benefits plans.

Non-Participating Provider

This term generally used to mean providers who have not contracted with a health plan to provide services at negotiated fees. Also called "non-preferred care provider."

O

Occupational Therapy

Treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, and bathing.

Out-of-Network

The use of health care providers who have not contracted with Aetna to provide services.

Outpatient: See Outpatient Care

Outpatient Care

Care provided in a clinic, emergency room, hospital or non-hospital surgical facility ("surgicenter") without admission to the hospital or facility.

Outpatient Surgery

Surgical procedures performed that do not require an overnight stay in the hospital or ambulatory surgery facility. Such surgery can be performed in the hospital, a surgery center, or physician office.

P

Partial Day Treatment

A program offered by appropriately-licensed psychiatric facilities that includes either a day or evening treatment program for mental health or substance abuse. Such care is an alternative to inpatient treatment.

Participating Provider

Any physician, hospital, skilled nursing facility, or other individual or entity involved in the delivery of health care or ancillary services which contracts to provide covered services to Plan participants for a negotiated charge. Also called “preferred care provider.”

Payment Limit

The maximum payment limit amount that a Plan participant will have to pay for expenses covered under the Plan. The payment limit maximum is the sum of all copayment or coinsurance amounts except as noted below. Once the Plan participant reaches the payment limit maximum(s), the Plan pays 100% of expenses for covered services for the remainder of the plan year. Certain expenses do not apply toward the payment limit maximum:

- Expenses that exceed Recognized Charge limits.
- Charges for services that are not covered by the Plan.
- Prescription drug copays.
- Mental health and substance abuse copay and coinsurance.

Physical Therapy

Treatment involving physical movement to relieve pain, restore function, and prevent disability following disease, injury, or loss of limb.

Plan

The self-funded High Level CPOSII product offered by the City of Scottsdale that represents a set of covered services or expenses accessible through a provider network, if applicable, or direct access to licensed providers and facilities.

Plan Participant

A subscriber or dependent who is enrolled in and covered by a health care plan. Also called “enrollee.”

Plan Year

Plan year is the twelve-month period from July 1 through June 30.

Preauthorization / Precertification Also known as “authorization,” “certification,” or “prior authorization”)

Certain healthcare services, such as hospitalization or outpatient surgery, require precertification by Aetna to ensure coverage for those services. When a Plan participant is to receive services requiring precertification through a participating provider, this provider should obtain the necessary precertification for those services prior to treatment. If not using a participating provider, you are responsible for obtaining the necessary precertification.

Preferred Care Provider: See Participating Provider

Prescription

An order of a licensed prescriber for a prescription drug. If it is an oral order, it must promptly be put in writing by the pharmacy.

Prior Authorization: See Pre-Authorization

Prosthetic Devices

A device that replaces all or a portion of a part of the human body. These devices are necessary because a part of the body is permanently damaged, is absent, or is malfunctioning.

Provider

A licensed health care facility, program, agency, physician, or health professional that delivers health care services.

Provider Network: See Network

R**Radiation Therapy**

Treatment of a disease by x-ray, radium, cobalt, or high-energy particle sources.

Recognized Charge

The covered expense is only that part of a charge which is the recognized charge.

As to medical, vision and hearing expenses, the recognized charge for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- For professional services and other services or supplies not mentioned below:
 - the 80th percentile of the Prevailing Charge Rate;for the Geographic Area where the service is furnished.

If Aetna has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply, then the recognized charge is the rate established in such agreement.

Aetna may also reduce the recognized charge by applying Aetna Reimbursement Policies. Aetna Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- the duration and complexity of a service;
- whether multiple procedures are billed at the same time, but no additional overhead is required;
- whether an assistant surgeon is involved and necessary for the service;
- if follow up care is included;
- whether there are any other characteristics that may modify or make a particular service unique; and
- when a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

Aetna Reimbursement Policies are based on Aetna's review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with physician or dental specialty society recommendations; and the views of physicians and dentists practicing in the relevant clinical areas. Aetna uses a commercial software package to administer some of these policies.

As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

- **Geographic Area:** This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.
- **Prevailing Charge Rates:** These are rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. Aetna updates its systems with these changes within 180 days after receiving them from FAIR Health.

Important Note

Aetna periodically updates its systems with changes made to the Prevailing Charge Rates. What this means to you is that the recognized charge is based on the version of the rates that is in use by Aetna on the date that the service or supply was provided.

Additional Information

Aetna's website aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Navigator to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools, or contact our Customer Service Department for assistance.

Respiratory Therapy

Treatment of illness or disease that is accomplished by introducing dry or moist gases into the lungs.

S

Second Opinion

The voluntary option or mandatory requirement to visit another physician or surgeon for an opinion regarding a diagnosis, course of treatment or having specific types of elective surgery performed.

Skilled Nursing Facility (SNF)

An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a skilled nursing facility, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by the health plan to meet the reasonable standards applied by any of the aforesaid authorities.

Speech Therapy

Treatment for the correction of a speech impairment that resulted from birth, or from disease, injury, or prior medical treatment.

Subscriber

The employee covered under the employer's group agreement. The subscriber can enroll eligible dependents as defined under "Eligibility."

Specialist

A physician who provides medical care in any generally accepted medical or surgical specialty or subspecialty.

T**Terminal Illness**

An illness of a Plan participant, which has been diagnosed by a physician and for which the patient has a prognosis of twelve months or less to live.

U**Urgent Care**

Services received for an unexpected illness or injury that is not life threatening but requires immediate outpatient medical care that cannot be postponed. An urgent medical condition requires prompt medical attention to avoid complications and unnecessary suffering or severe pain, such as a high fever.

W**Well Baby/Well Child Care**

Refers to routine care, testing, checkups and immunizations for a generally healthy child from birth through the age of eight.

Wellness Program

A health management program that incorporates the components of disease prevention, medical self-care, and health promotion. It utilizes proven health behavior techniques that focus on preventing illness and disability which respond positively to lifestyle related interventions.

ATTACHMENT A

PRIVACY OF PROTECTED HEALTH INFORMATION

1. **Definitions.** The terms used in this *Privacy of Protected Health Information* attachment shall have the definitions ascribed in HIPAA and its implementing regulations.
2. **Employer's (Plan Sponsor's) Certification of Compliance.** Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Members' protected health information to the Employer (plan sponsor) unless the Employer (plan sponsor) certifies that the Plan documents have been amended to incorporate this *Privacy of Protected Health Information* attachment and agrees to abide by this *Privacy of Protected Health Information* attachment.
3. **Purpose of Disclosure to Employer (Plan Sponsor).**
 - (a) The Plan and any health insurance issuer or business associate servicing the Plan will disclose Members' protected health information to the Employer (plan sponsor) only to permit the Employer (plan sponsor) to carry out plan administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-64). Any disclosure to and use by the Employer (plan sponsor) of Members' protected health information will be subject to and consistent with the provisions of paragraphs 3 and 4 of this *Privacy of Protected Health Information* attachment.
 - (b) Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Members' protected health information to the Employer (plan sponsor) unless the disclosures are explained in the Notice of Privacy Practices distributed to Subscribers.
 - (c) Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Members' protected health information to the Employer (plan sponsor) for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer (plan sponsor).
4. **Restrictions on Employer's (Plan Sponsor's) Use and Disclosure of Protected Health Information.**
 - (a) The Employer (plan sponsor) will neither use nor further disclose Members' protected health information, except as permitted or required by the Plan documents, as amended, or required by law.
 - (b) The Employer (plan sponsor) will ensure that any agent, including any subcontractor, to whom it provides Members' protected health information agrees to the restrictions and conditions of the Plan documents, including this *Privacy of Protected Health Information* attachment, with respect to Members' protected health information.
 - (c) The Employer (plan sponsor) will not use or disclose Members' protected health information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer (plan sponsor).
 - (d) The Employer (plan sponsor) will report to the Plan any use or disclosure of Members' protected health information that is inconsistent with the uses and disclosures allowed under

this *Privacy of Protected Health Information* attachment promptly upon learning of such inconsistent use or disclosure.

- (e) The Employer (plan sponsor) will make protected health information available to the Member who is the subject of the information in accordance with 45 Code of Federal Regulations § 164.524.
- (f) The Employer (plan sponsor) will make Members' protected health information available for amendment, and will on notice amend Members' protected health information, in accordance with 45 Code of Federal Regulations § 164.526.
- (g) The Employer (plan sponsor) will track disclosures it may make of Members' protected health information so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528.
- (h) The Employer (plan sponsor) will make its internal practices, books, and records, relating to its use and disclosure of Members' protected health information, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 Code of Federal Regulations Parts 160-64.
- (i) The Employer (plan sponsor) will, if feasible, return or destroy all Member protected health information, in whatever form or medium (including in any electronic medium under the Employer's (plan sponsor's) custody or control), received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Participant who is the subject of the protected health information, when the Members' protected health information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Member protected health information, the Employer (plan sponsor) will limit the use or disclosure of any Member protected health information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

5. Adequate Separation Between the Employer (Plan Sponsor) and the Plan.

- (a) The following employees or classes of employees or other workforce members under the control of the Employer (plan sponsor) may be given access to Members' protected health information received from the Plan or a health insurance issuer or business associate servicing the Plan:

Senior Benefit Analyst and staff of the City of Scottsdale designated by the Senior Benefit Analyst

- (b) The employees, classes of employees or other workforce members identified above will have access to Members' protected health information only to perform the plan administration functions that the Employer (plan sponsor) provides for the Plan.

The employees, classes of employees or other workforce members identified above will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer (plan sponsor), for any use or disclosure of Members' protected health information in breach or violation of or noncompliance with the provisions of this *Privacy of Protected Health Information* attachment. The Employer (plan sponsor) will promptly report such breach, violation or noncompliance to the Plan, as required by paragraph 3(d) of this *Privacy of Protected Health Information* attachment, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or

sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Participant, the privacy of whose protected health information may have been compromised by the breach, violation or noncompliance.

Effective April 21, 2005 in compliance with **HIPAA Security** regulations, the Plan Sponsor will:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,
2. Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and report to the Plan any security incident of which it becomes aware concerning electronic PHI.